"*It happens to clinicians too*": The prevalence, impact and implications of domestic and family violence against health professional women

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Dedication

To my dear mum, Veronica Mary Azzopardi McLindon, who died three days before Christmas, 2015. Such a beautiful, intelligent, compassionate and inspiring woman. Thank you for being enormously supportive of this PhD; proud, interested and always taking care. I wish I could share this ending with you.

To my sons, Leo and Felix O'Sullivan McLindon, born first at two and half years, and second, five years, into this project. I have walked into motherhood and through a PhD at the same time. What great luck to have you in my life. To come back to you at the end of each day; to be reminded of what matters during the really hard bits. To walk alongside you for life. Fight the good fight my dears.

This work is for the three of you.

Abstract

Domestic and family violence (DFV) is a major health and social issue in Australia and across the globe. It affects people of all ages and walks of life, predominantly women and children. DFV is associated with a range of harms and impacts, and more frequent utilisation of health services is one. Consequently, health professionals find themselves at the frontline of responding to the health sequelae of violence and trauma in the family. However, healthcare is a gendered profession, where the majority of employees are women. How commonly DFV affects Australian women working in healthcare, and what, if any, association there is between a health professional's personal experience of DFV and their clinical care of patients accessing healthcare for DFV, is not known. An additional gap in the evidence-base is understanding the needs and perspectives of both survivor health professionals and key stakeholders about the role of the healthcare workplace in supporting survivor staff, not just patients.

To address these research gaps, the aim of this PhD study was to investigate the prevalence, clinical care impacts and workplace implications of DFV against an Australian population of women nurses, doctors and allied health professionals. This study utilised a combined methodological approach to collect both quantitative and qualitative data. The first phase of the project was a descriptive, cross-sectional survey of health professionals at a large Australian tertiary maternity hospital, in which 471 health professional women participated (45.0% response rate). Phase two followed, and individual and group interviews were conducted with 18 hospital managers and other key stakeholders.

The original contributions of this thesis to new knowledge was the finding that DFV was common in the lives of the health professional women in this study: intimate partner violence (IPV) had affected one in ten (11.5%, 43) women during the last 12-months, and one third (33.6%, 146) of women since the age of sixteen. Sexual violence by an intimate partner was reported by 12.1% (51) of health professional women. Overall, just under half (45.2%, 212) of the participating health professional women had experienced IPV or violence from another family member (including childhood witnessing of DFV) across the life course.

The second original finding of this study was that a health professional's experience of DFV appeared to facilitate clinical care of survivor patients. Specifically, exposure to DFV was positively associated with preparedness to care for survivor patients through greater uptake of professional DFV training, more sensitive attitudes about survivors and more frequent access of information with which to resource survivor patients.

The final original knowledge contribution was how hospital workplaces can best support their survivor staff, drawing on the perspectives and experiences of both survivor health professional women (*n*=93) and hospital managers (*n*=18). Survivors wanted their workplace to understand that DFV had affected them and to support both their individual needs and recovery as well as their professional capacity to respond to survivor patients. Managers recognised the imperative of a hospital workplace to ensure the availability of multifaceted support for survivor staff, and suggested mechanisms for this. Safety emerged as a key barrier to a more supportive workplace for survivor staff; participants were clear that occupational violence could render a workplace physically unsafe, and fear or uncertainty about how a disclosure of DFV would be responded to affected feelings of emotional safety.

The findings of this thesis are presented across three publications. The results indicate that the cumulative trauma burden in Australian health professional women's lives is high. That burden is added to by the risk of vicarious trauma that all health professionals face in a role where listening to patient histories of trauma and violence is routine. However, the survivors in this study did not present as enduringly vulnerable; on the contrary, they self-reported an informed and sensitive readiness to respond to patients with whom they have DFV in common. This research indicates the efficacy of a trauma and violence-informed framework to underscore and strengthen a recovery-orientated hospital response towards both survivor staff *and* patients.

Declaration

I, Elizabeth Veronica-Mary McLindon, do hereby declare:

i. This thesis comprises only my original work towards the degree of Doctor of Philosophy, except where indicated in the preface;

ii. That due acknowledgement has been made in the text to all materials used; and

iii. This thesis does not exceed the word limit of 100,000 (excluding tables, bibliography, and appendices).

Table of Contents

List of Tables

List of Figures

Acknowledgement of Country

I would like to acknowledge that this work was thought about, researched and written on the traditional lands of the Wurundjeri People of the Kulin Nation. I pay my respect to Aboriginal and Torres Strait Islander elders past, present and emerging. I acknowledge the devastating and ongoing impacts of transgenerational trauma and racism. I sincerely value Aboriginal and Torres Strait Islander history, culture, knowledge and lived experience.

Always was, always will be Aboriginal land.

Acknowledgement of Survivors

I would like to acknowledge the survivors of gender-based violence who read this work and who contributed to it. I acknowledge the enormous and multifaceted harm of all forms of violence against women. I have been indelibly influenced in my thinking and approach by the survivors I have had the privilege of knowing and with whom I have worked. I take courage from both your strength and your confrontation of the fear and pain. I hope that this work is sensitive to your experience.

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This thesis has taken a long time, and MANY people. Without them, it would probably not have started and would certainly not have finished.

First and foremost, I thank my darling husband, Andrew O'Sullivan, who held me and this ship together throughout the journey. You have been critical to my PhD, Andrew. Thank you for loving, encouraging and believing in me. Thank you for putting up with the slog. For all the missed family time. For repeating often that your priority was doing what needed to be done so that the thesis was completed. Thank you for supporting me through all of the big life stuff that happened to both of us during the eight years this thesis took. One thousand times thank you.

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Thank you, Mum. Mum was a tireless human rights campaigner and an eternal optimist. Mum, you are in everything I do, still with me every day.

Thank you, Leo and Felix. Right now, you are too young to read these words, but one day I will tell you about how you helped and motivated me; distracted and calmed me. I learnt to parent you both while writing this "enormous book" (as you call it, Leo). Your cuddles and I-Love-You's are seriously the best. The best.

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I stand on the shoulders of giants. I want to acknowledge the feminist activists, scholars and ancestors who have come before me, from whom I have learnt and who have made my journey easier. To quote Gill Hague and Audrey Mullender: The debt is clear.

As I finish this thesis, the world is responding to the catastrophe of the COVID-19 pandemic. I want to thank all of those who are working so hard in healthcare and violence against women at this moment. We are all in this together.

Acronyms & abbreviations

AAS	Abuse Assessment Screen
ACE	Adverse Childhood Experiences
ANMF	Australian Nursing and Midwifery Federation
CAS	Composite Abuse Scale
CEO	Chief Executive Officer
CPG	Clinical Practice Guideline
CTS2	Conflict Tactics Scale 2
DFV	Domestic and family violence
DV	Domestic violence
FV	Family violence
HP	Health professional
HR	Human Resources
ID	Identification
IPV	Intimate partner violence
Mth	Month
PREMIS	Physician Readiness to Manage Intimate partner Violence Survey
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines
PSS	Personal Safety Survey
SCA	Severe Combined Abuse
SHRFV	Strengthening Hospital Responses to Family Violence
UK	United Kingdom
USA	United States of America
VAW	Violence Against Women
WAST	Woman Abuse Screening Tool
WAV	Women Against Violence
WHO MCS	World Health Organization Multi-Country Study on Women’s Health and Domestic Violence

Preface

SCHOLARSHIP

This research was supported by a 2012 Sidney Myer Health Scholarship. The scholarship provided a stipend and money for associated costs including conferences.

PUBLICATIONS

In this thesis, I present the major findings in publication format across three manuscripts and corresponding Chapters. My contribution to each of these manuscripts was 90% or more. I was responsible for all aspects of these studies, including writing the ethics applications, recruitment, data collection, analysis and write up. My supervisors and co-authors, Professors Kelsey Hegarty and Cathy Humphreys, contributed by conceptualising the studies with me, providing supervision and feedback and critically reviewing the draft manuscripts in preparation for publication. All authors approved the final manuscripts.

The following three peer-reviewed manuscripts have been published in academic journals:

Chapter 4

McLindon, E., Humphreys, C., & Hegarty, K. (2018). "It happens to clinicians too": An Australian prevalence study of intimate partner and family violence against health professionals. *BMC Womens Health, 18*.

Chapter 5

McLindon, E., Humphreys, C., & Hegarty, K. (2019). Is a clinician’s personal history of domestic violence associated with their clinical care of patients: A cross-sectional study. *BMJ Open, 9*(7).

Chapter 6

McLindon, E., Humphreys, C., & Hegarty, K. (2020). *Hospital responses to staff who have experienced domestic and family violence*: A qualitative study with survivor health professionals and hospital managers. *Journal of Gender-Based Violence*.

CONFERENCE PRESENTATIONS

Some of the findings of this thesis have been presented at national and international conferences:

McLindon, E., Humphreys, C., & Hegarty, K. (2020, June 30 – July 2). Survivor Health Professionals: Is personal history of gender-based violence associated with clinical care of survivor patients and what about the role of the healthcare workplace? The Nursing Network on Violence Against Women International Conference, Malmo, Sweden (Conference cancelled due to COVID-19; abstract published: NNVAWI. (2020). *NNVAWI Abstracts.* Global Qualitative Nursing Research, 7, page 49).

McLindon, E., Humphreys, C., & Hegarty, K. (2018, November 20-21). *The survivor nurse: Implications for health professionals and their workplace.* International Domestic Violence and Health Conference, Melbourne, Australia.

McLindon, E., Humphreys, C., & Hegarty, K. (2017, September 26-28). *Identifying the effect of domestic and family violence personal experience on a health professionals' clinical practice with survivor patients.* Futures Without Violence Conference, San Francisco, USA. (E. McLindon in absentia due to maternity leave, K. Hegarty delivered presentation).

McLindon, E., Humphreys, C., & Hegarty, K. (2017, April 21-23). *How does intimate partner and family violence affect health professional women and what are the implications for the healthcare workplace?* Trauma 2017 Australasian Conference, Melbourne, Australia.

McLindon, E., Hegarty, K., & Humphreys C. (2016, October 26-28). *It happens to clinician's too: Intimate partner, family and sexual violence amongst health professionals.* Nursing Network on Violence Against Women International, Melbourne, Australia.

McLindon, E. (2016, October 18). *The impact of intimate partner, family and sexual violence against health professionals.* Melbourne School of Health Sciences 2016 Graduate Research Student Colloquium, Melbourne, Australia.

McLindon, E. (2015, September 10-11). *It happens to health professionals too: Domestic violence & sexual assault in the context of caring for patients who have experienced violence.* Australian Nurses and Midwives Conference, Melbourne, Australia.

McLindon, E. (2015, June 25). *It happens to health professionals too: Domestic violence & sexual assault in the context of caring for patients who have experienced violence.* Australian Nursing and Midwifery Federation (Victorian Branch) Annual Delegates Conference, Melbourne, Australia.

McLindon, E., Hegarty, K., & Humphreys C. (2015, March 20-21). *It happens to health professionals too: Domestic violence & sexual assault in the context of caring for patients who have experienced violence.* Futures Without Violence Conference, Washington, USA (E. McLindon in absentia due to maternity leave, K. Hegarty delivered presentation).

McLindon, E. (2014, October 9). *The Women Against Violence Project: Researching health professional's experiences of gendered violence and the impact on clinical care.* Melbourne School of Health Sciences 2014 Graduate Research Student Colloquium, Melbourne, Australia.

Maher, H., & McLindon, E. (2012, March 29-31). *Using a whole of hospital approach to advance health care for women affected by domestic violence.* Futures Without Violence Conference, San Francisco, USA.

COURSES

During candidature, I undertook the following subjects at the University of Melbourne:

- *Research Processes (SCWK90047)* Semester 1, 2012 (H1);

- *Ethical Leadership* - Graduate Certificate in Advanced Learning and Leadership (GCALL), August 2012 (H1);

- *The Futures Project* – GCALL - July 2013 (H1).

In addition, I completed the following week-long courses at the Australian Consortium for Social and Political Research Inc. (ACSPRI):

- *Fundamentals of Statistics*, 20-24 January 2014, Australian National University, Canberra, Australia;

- *Data Analysis using Stata*, 3-7 February 2014, The University of Melbourne, Melbourne, Australia;

- *Fundamentals of Multiple Regression*, 27 June - 1 July 2016, The University of Queensland, Brisbane, Australia.

MEMBERSHIP

I was a member of the first Doctoral Academy convened by the Melbourne Social Equity Institute in 2014. The Academy supported my professional development with academic mentoring and financial support.

PROOFREADING

Ms Hayley Rochelle Pulham-Anderson proofread this thesis for spelling and grammatical errors in accordance with Guidelines for the Editing of Research Theses by Professional Editors. Ms Pulham-Anderson has not undertaken formal study in the academic discipline of this thesis.

Brief story behind this thesis

I am a social worker and my history of clinical work has been with women experiencing violence. For fifteen years, I have listened and responded to stories of hurt, broken trust, self-blame, stigma and shame. My job has been to bear witness, to engender hope, to walk alongside women on their path towards safety. These are routes women start establishing at the onset of violence and our work together is in widening and weather-proofing those roads, spotlighting the harm from places of emotional safety, talking about the hard and frightening: their children, community, house, future. To work on the body and mind responses that arise from attack, terror and injury. To work towards change within the systems of which women are part.

Other than sitting in rooms with survivors, I have stood with nurses and doctors, discussing, collaborating, caring for our patients with violent histories. Part of my job has been to formally train clinicians to grow their capacity to identify and respond to survivor patients. I became used to staff hanging around after these training sessions; packing away their things more slowly than their colleagues. I grew to recognise staff that were readying to unload personal stories of abuse, and to talk about the intersection between being a survivor and a clinician. These conversations with survivor colleagues led to wonderings: *How common is DFV in health professionals' lives? Do survivor health professionals approach their clinical work with survivor patients differently than their non-abused peers? What do survivor clinicians need and what would ideal workplace support look like?*

The lived experiences that survivor women have shared with me are at the heart of this thesis. My purpose in undertaking a PhD research apprenticeship was to learn how to find answers to my research and practice questions, so that I may be better able to sit in the hurt, with the darkness, because I am concurrently working towards shedding light. By the conclusion of this PhD, I belong to two worlds: that of the clinician and researcher. I hope that this thesis is sensitive to those who have experienced domestic and family violence and sexual assault. I also hope that it is a rigorous account of the work I did to find answers to questions about domestic and family violence in the lives of a hidden group of survivors: health professional women. I hope that it may contribute to enhanced understanding, care and support. Thank you for reading this work.

Part I

Background

1.

Introduction

"Even by completing this study, I realise that I'm again in a somewhat violent relationship and I need to take steps to fix things up and move the other person on. Thanks for raising awareness amongst all the staff - I don't know anyone else in the hospital who has ever experienced violence at home except me – [it's] *not talked about –* [it's] *impolite I guess…I often wish I had more time to spend with a patient who discloses things, to be an empathic ear - at least there are people that can help women get help and help women feel safe to disclose."*

(Survivor health professional participant)

"Look, I think as an employer, and as a large employer…we do have a role in supporting staff who have been subject to violence."

(Hospital manager participant)

Violence against women, including domestic and family violence (DFV), is a chronic and serious social health issue (Australian Institute of Health and Welfare, 2018). Strong evidence over the last three decades has established it is caused by gender inequality and patriarchal social norms (Flood & Pease, 2009; Heise, 1998; Our Watch & VicHealth, 2015; World Health Organization, 2012). Gender is the most critical variable when considering differences in the lived experience of surviving and perpetrating DFV; the vast majority of DFV survivors are women and the person who uses violence against them is usually a well-known male (Australian Institute of Health Welfare, 2019; Cox, 2015; World Health Organization, 2012). DFV affects up to a quarter of Australian women in adult life (Australian Bureau of Statistics, 2017). More than four times as many Australian women than men report having felt anxious or frightened during the most recent incident of physical assault by their opposite-sex partner (Cox, 2015). Many children are impacted by DFV too; the majority of women with children in their care at the time of DFV report that their child saw or heard the violence (Australian Bureau of Statistics, 2017). Further, population surveys show that one in six girls and one in nine boys have been physically or sexually abused before their fifteenth birthday (Australian Bureau of Statistics, 2017). The health costs at the level of the individual, the workplace and the broader community are considerable (Price Waterhouse Coopers, 2015). These health effects contribute to an overrepresentation of DFV survivors within the health care system (Australian Institute of Health and Welfare, 2018). Hospitals have long recognised the opportune position they occupy in identifying and intervening early with women experiencing DFV (García-Moreno et al., 2015; Spangaro, Poulos, & Zwi, 2011). For some women, especially those who have become isolated from family and friends, or whose movements are being tightly controlled by an abusive partner, a hospital or other health service may be one of the only places where she can speak with a professional who has the authority to see her alone. It is within this context that health professionals are positioned at the forefront of responding to DFV in our community (World Health Organization, 2016).

The caring profession, like DFV, is overwhelmingly gendered (Australian Institute of Health and Welfare, 2016b). Nurses, midwives and carers comprise the largest clinical group of employees in Australian hospitals, and 90% of these health professionals are women (Australian Institute of Health and Welfare, 2016b). Given the number of DFV survivors accessing healthcare, evidence-based training and support for the mostly female health professionals tasked with identifying and responding to survivor’s needs would seem critical. Accordingly, much research has explored the barriers and facilitators to health professional’s readiness to respond to DFV in healthcare (Sprague et al., 2012). Some research has suggested that a health professional’s personal experience of DFV may facilitate heightened readiness to identify and respond to survivor patients (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). However, other research has indicated that personal DFV exposure might act as a barrier to DFV clinical care (Mezey, Bacchus, Haworth, & Bewley, 2003). Within this milieu, understanding the prevalence of DFV in the personal lives of health professional women, the possible impact of this type of trauma on clinical care of survivor patients, and the implications for hospital workplaces, may benefit both survivor health professionals and their patients.

Previous research about the prevalence of DFV against health professionals is scant, of varying quality, and set outside Australia. International published lifetime prevalence rates also vary considerably: from 3.7% of doctors in the United States of America (USA) (Doyle et al., 1999), to 51.4% of nurses in Guyana (South America) (Mitchell, Parekh, Russ, Forget, & Wright, 2013). A USA study with a similar population lifetime DFV prevalence rate to Australia found nurses’ exposure to DFV mirrored that of women in the broader community at 25% (Bracken et al., 2010). However, there are problems with the few studies on the topic of DFV against health professionals, including a lack of rigour in the assessment of DFV (Bracken et al., 2010; Candib et al., 2012), small sample sizes (Al-Natour, Gillespie, Wang, & Felblinger, 2014; Janssen, Basso, & Costanzo, 1998) and unpublished or low response rates (Cavell Nurses' Trust, 2016; Sharma & Vatsa, 2011).

Evidence about whether a health professional’s lived experience of DFV influences their clinical care of survivor patients is mixed. Of the handful of studies on this topic, half found a relationship between a clinicians’ DFV history and their clinical care of survivor women (Candib et al., 2012; Christofides & Silo, 2005), while the other half did not (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Stenson & Heimer, 2008). To date, research has not investigated the organisational response within hospitals towards survivor staff in terms of either personal or professional support (García-Moreno et al., 2015). Survivor health professionals have not been asked about their needs and experiences in a workplace in which they interact daily with patient survivors of DFV.

Research from other sectors of the workforce suggests that employers have an important role in supporting survivor staff but there may be a mismatch between what survivors want from their workplace, and that which they actually receive (Laharnar, Perrin, Hanson, Anger, & Glass, 2015; Swanberg, Logan, & Macke, 2005). The only Australian study of survivor employees was conducted with education and nursing union members and found that while disclosure of DFV within the workplace was not uncommon, most survivors reported that the organisational response they received was either silent or adverse (McFerran, 2011).

1.1 LANGUAGE USED IN THIS THESIS

Language to describe DFV is contested, constantly evolving and context-dependent (Yates, 2020). Many of the most commonly used terms, including *violence against women; domestic violence; domestic abuse; intimate partner violence; family violence;* and *gender-based violence* have disparate meanings in different regions and have their genesis in diverse theoretical perspectives and disciplines (Ellsberg & Heise, 2005). For example, the term *family violence,* increasingly the preferred term in Victoria, Australia, is not used in the United Kingdom (UK), where their terms of choice, *domestic assault* and *domestic abuse,* do not have resonance in Australia (Yates, 2020).

Violence against women (VAW) is the umbrella term for a range of physically, sexually, psychologically and economically abusive behaviours disproportionally directed at women and girls by men they know, often a partner or family member (Ellsberg & Heise, 2005). I have chosen to use the term *domestic and family violence* (DFV) throughout this thesis. This choice is in alignment with the international framing of DFV as located within VAW; a result of gender inequality (Yates, 2020). Cautious of ‘gender neutrality’, I will refer to DFV survivors using the female pronoun. DFV and other important terms used throughout the thesis are now introduced and their specific application defined. When citing literature in the field, I employ their terminology.

Domestic and family violence

Domestic and family violence (DFV) defines abusive behaviours as those that result in or are likely to result in physical, psychological, economic or sexual harm or suffering, including the threat of such acts or coercion into them, occurring across the life course (Australasian Legal Information Institute 2008; Yates, 2020). I utilise the term in alignment with the perspective of Yates (2020) (among others) who describes DFV as incorporating, "*the sex-asymmetry of intimate partner violence implied by the term 'domestic violence', and 'family violence' in deference to Aboriginal and Torres Strait Islander perspectives on the problem*" (p. 2).

When the term DFV is used within this thesis it specifically refers to acts of violence by either an intimate partner or non-intimate family member, including witnessing violence between one's parents during childhood.

Family violence

Family violence (FV) can refer to actions or behaviours by an intimate or non-intimate family member that are physically, sexually, emotionally or economically abusive, threatening or coercive or that cause the family member to feel fear for their safety or wellbeing (Australasian Legal Information Institute 2008; Ellsberg & Heise, 2005). FV includes behaviour that is witnessed or heard by a child. In Victoria, Australia, FV has long been the preferred term employed throughout both the practitioner, policy and research spheres (Yates, 2020). This was reinforced by the Victorian Royal Commission into Family Violence (State of Victoria, 2014-16). FV is a term preferred by Australian Aboriginal and Torres Strait Islander peoples as better reflecting their experiences because it references extended families and communities (Olsen & Lovett, 2016). While FV refers to abusive behaviour that can occur in families of diverse configurations, in the local Victorian context, it is usually used to describe behaviour by an intimate partner against his current or former partner and her children (State of Victoria, 2014-16). While a strength of this term is its inclusivity, a limitation is its lack of signalling about gender and power dynamics since not all forms of FV are as sex asymmetrical as, for example, IPV (DeKeseredy, 2016; Yates, 2020).

When FV is used within the thesis it specifically refers to acts of violence by a non-intimate family member, including witnessing.

Intimate partner violence

Intimate partner violence (IPV) is a term used to describe physical, sexual and psychologically abusive, controlling and harmful behaviours by an intimate partner (Krug et al., 2002). While violence can occur in same-sex relationships, and some women use violence, most commonly, the perpetrators of IPV are male intimate partners and ex-partners against women with whom they have been in a relationship (World Health Organization, 2012).

IPV is used within this thesis to specifically refer to violence by a co-habiting or non-co-habiting intimate partner (i.e. boyfriend, husband, etc), with whom there has been an established relationship (e.g. for 6-months or more). IPV is used when referring to findings from the Composite Abuse Scale (CAS), since this this a specific measure of abusive behaviours perpetrated by an intimate partner (Hegarty, Bush, & Sheehan, 2005). Within this thesis, IPV does not include dating, casual or hook-up type relationships.

Sexual assault

The term sexual assault describes acts of a violent sexual nature carried out without a person’s consent using force, intimidation or coercion (Cox, 2015). Sexual assault includes rape, attempted rape and other forced sexual activity by an intimate partner, acquaintance or stranger. Sexual assault can be perpetrated by adults against other adults or children (World Health Organization, 2012). Sexual assault does not include unwanted sexual touching, which can be defined as ‘sexual harassment’ (Cox, 2015).

Within this thesis, ‘sexual assault’ is used to refer to items in the CAS that reference rape and attempted rape (Hegarty et al., 2005). It is also used to identify abuse or violence of a sexual nature as labelled by participants in response to a question about violence or abuse perpetrated by somebody other than a partner or family member.

Trauma

The term ‘trauma’ is used throughout this thesis to mean both the experience of, and the response to, an event of overwhelming danger (or repeated events) such as DFV (Herman, 1992; Ponic, Varcoe, & Smutylo, 2016). Traumatic events and episodes threaten a person’s physical or psychological integrity and can cause feelings of acute distress, fear or terror (Mészáros, 2010). Trauma is a complex reaction that may include intrusive reliving, anxiety, hopelessness, numbing and disconnection that exceeds an individual’s coping capacity (Harms, 2010; Herman, 1992).

Health professional

A ‘health professional’ is a person working in a clinical capacity within a health setting, including nurses, doctors, midwives, social workers and other allied health professionals (Australian Institute of Health and Welfare, 2016a). Within this thesis, the term denotes someone belonging to a registered health profession (i.e. nurses and doctors) or associated tertiary qualified health profession (i.e. social workers). The words ‘clinician’ and ‘staff’ are used interchangeably with ‘health professional’ and are attributed the same meaning.

Patient, Woman

The terms ‘patient’ and ‘woman’ are used interchangeably to refer to a person who is accessing inpatient or outpatient treatment or intervention from a health service. Within this thesis, a patient or woman is usually someone receiving care from the tertiary hospital research site, and since it was a maternity service, *patient* or *woman* usually refers to a pregnant woman receiving outpatient maternity care.

Survivor

The term survivor denotes people, commonly women, who have experienced gendered and familial abuse and violence (Elliott, Bjelajac, Fallor, Markoff, & Reed, 2005). This word recognises the strength and resilience of people with lived experience of DFV who continue to survive. The term acknowledges the perpetrator’s abuse of power and responsibility for their actions. While the term *victim/survivor* identifies both the harm of

DFV and the possibility for growth through empowerment, I wanted to minimise the use of double-barrelled terms within this thesis in the interests of brevity (Sexual Assault Kit Initiative, 2019). The term *survivor* is used to describe someone who has experienced DFV, and in this work, that is usually a health professional or patient.

Primary & secondary exposure to DFV

When critiquing the literature, it was necessary to draw a distinction between people who had experienced primary and secondary exposure to DFV. The term ‘primary exposure to DFV’ indicates a person who has experienced DFV themselves, including being present to DFV as a child. The term ‘secondary exposure to DFV’ is used to characterise someone who has not experienced DFV firsthand, but rather, has borne it witness through listening to another, be they a friend, family member, colleague or patient, with direct experience of DFV (Christiansen, Bak, & Elklit, 2012).

1.2 POSITIONING MYSELF AS A RESEARCHER

Throughout this thesis, at times I use the personal pronouns, “I” and “we”. Writing in this way signals that the ideas, interpretations and arguments in this thesis are mine, influenced by my outlook, experience, reflexivity and close collaboration with supervisors (Kuo, 1999; Tang & John, 1999). I am greatly fortunate that my personal story does not include DFV. However, I can reflect that having significant others in my life who have experienced childhood abuse, sexual assault, intimate partner violence and family violence is likely to have influenced my decision to study and work in the field of violence against women, albeit at a subconscious level.

I came to this research as an insider in the sense that this project was born of questions I started to pose whilst working clinically with women who had experienced DFV and sexual assault. I trained as a social worker with a double undergraduate degree in psychology. Throughout my fifteen years as a social worker in hospitals working with women who have experienced violence and other oppressions, the theoretical underpinnings of my practice has been feminist (Skinner, Hester, & Malos, 2005), strengths-based (Saleebey, 1992), systemic (Bronfenbrenner, 1992) and trauma-informed (Harris & Fallot, 2001). Social work practice with DFV survivors is aimed at first addressing safety, then working on the biopsychosocial impacts, with the long-term goal of recovery (Lundy, 2008). The term recovery does not imply the absence of trauma impacts, but rather being able to function within a new world view on a personal, social and occupational level (Harms, 2015). It also entails the survivor having reduced signs/symptoms of trauma (Australian Centre for Posttraumatic Mental Health, 2013). Running in the background to that work are structural oppressions, including gender inequity, that drive DFV (United Nations Women, 2010). This project is informed and motivated by my learnings from the women and health professional colleagues who I have known and with whom I have worked, the questions that remained after our work had concluded, and my commitment to contributing to policy and practice that has the potential to impact the macrosystem (Bronfenbrenner, 1992).

1.3 INSIDER & OUTSIDER RESEARCH

Both insider and outsider perspectives can add richness to research, however, an inherent tension can exist between them (Patton, 2002). I started this study as an insider researcher working as a clinical social worker within a large tertiary hospital. My intention was to investigate a system of which, as an employee, I was a part, and that I believed in because of my anecdotal sense of its effectiveness. I had worked at this hospital for several years by this point, first as a general hospital social worker and then as a counsellor/advocate at the sexual assault counselling service. Part of my role was to advance the hospital's responsiveness to DFV, including by strengthening the confidence of health professional staff through training and capacity building with other hospitals. My employer supported my idea to answer research questions born from practice through the process of a PhD, while continuing clinical work part-time. As an employee at the research site, I had the opportunity to bring staff, managers and executive on the research journey. This was an early foreshadowing of how being *within* could benefit a project. I was able to access in-kind hospital support, a donation from the hospital cafeteria to incentivise participation, and the hospital Chief Executive Officer (CEO) encouraged staff to participate in the survey during work time. Being an insider and someone committed to feminist research principles demanded caution, thoughtfulness and reflection (Leung, Miedema, Warner, Homan, & Fulu, 2019). As a quantitative and qualitative study - an approach selected to collect both quantifiable and exploratory data – data triangulation and strong supervision challenged me to apply a high level of rigour to the research questions, data analysis and conclusions (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Embedding a feminist approach in order to ask and answer more meaningful research questions, I strove to ensure the project was ethical, collaborative, accountable, accessible and open (International Women's Development Agency, 2017; Leung et al., 2019).

The process of doing this PhD has kept moving me further and further into the space of an outsider (Bartunek & Louis, 1996). Starting slowly through full-time enrolment at University and a reduction in days of clinical work, it was furthered by consciously positioning myself outside the organisation. This influenced how the research questions were posited, application of the method and analysis of the results. Every PhD has a shadow story of life lived during its pursuit. The shadow story of this PhD includes the birth of my two sons, the first who arrived two and a half years into this project, upon conclusion of data collection and in the middle of analysis and writing. During my first child's first year, my mother died. My second son came five years into the project. These births and death forced long leaves of absence from my clinical role and candidature, prompting time and space to think differently. Acknowledging that I am both an *insider* and *outsider* feminist researcher, I have tried to be conscious of my background, values and motivation for doing this research, always considering my bias. As Kuo (1999) suggests, I acknowledge my intention that this work add to the knowledge base, further break the silence about experience, influence policy, and advance a program of research. Walking into motherhood and through a PhD at the same time has significantly elongated, and enriched, this research apprenticeship. By thesis submission, I will be just shy of running the PhD clock to four years full-time equivalent, which is eight years of real time comprising part-time candidature and periods of maternity leave.

1.4 CONTRIBUTION OF THE THESIS

This dissertation will make three distinct contributions to the field of understanding and supporting health professional survivors of DFV. Firstly, it will provide the first Australian prevalence study of DFV against health professional women. Secondly, it will take a substantive position in the argument about whether being exposed to DFV affects health professionals' clinical care of survivor women. Thirdly, it will present the implications for the hospital workplace derived through listening to survivor employees' needs and hearing the perspectives of the managers responsible for administration of employment. This thesis is designed to benefit practitioners and researchers seeking to understand and support survivor employees in the healthcare workplace. The main purpose of the thesis, however, is to continue a long tradition of breaking the silence about VAW in order to better understand, support and care for survivor women.

1.5 AIM & RESEARCH QUESTIONS

The aim of this research is to investigate the prevalence, impacts and implications of DFV against a population of Australian health professional women. The following four research questions are intended to answer this overarching aim:

1. *What is the prevalence of DFV and other interpersonal violence in an Australian health professional population?*
2. *Do health professional's personal experiences of DFV affect their attitudes about DFV, comfort to discuss the issue with women, enquiry and response towards survivor women?*
3. *What support needs do survivor health professionals have of their hospital workplace?*
4. *What are the views of key stakeholders about the role of the workplace in responding to staff survivors of DFV?*

1.6 THESIS OUTLINE

This thesis with publication is structured in three parts. Part I consists of three Chapters; this Introduction, the Literature Review and the Methodology. In Part II, three peer-reviewed published articles (Chapters 4-6) present the findings. In Part III, the thesis is discussed, the implications considered, and the thesis concluded.

PART I – BACKGROUND TO THE RESEARCH (CHAPTERS 1-3)

Chapter 2 – Literature Review. This Chapter thoroughly examines the context of DFV against health professionals in Australia. It begins by outlining the role of hospitals in responding to DFV in the community, the rationale for understanding more about the personal experience of the health professionals who work within that system, and the broader implications for the healthcare workplace. The Literature Review Chapter ends by establishing the research gap justifying this dissertation.

Chapter 3 – Methodology. This Chapter commences by discussing the quantitative and qualitative design to answer the research questions informed by the aim. Next, the reasons for selecting this approach, as well as the theories that underpin the work are presented. The cross-sectional survey and interview methods for the two phases of the study are detailed, as are the ethical issues addressed by this project.

PART II – RESULTS (CHAPTERS 4-6)

Chapter 4 – DFV prevalence study. This Chapter is a prevalence study of 12-month and lifetime DFV against female health professionals in Australia. A published manuscript titled, "*It happens to clinicians too*": An Australian prevalence study of intimate partner and family violence against health professionals', is followed by additional results.

Chapter 5 – Clinical care impacts study. This Chapter describes the results of a study about the relationship between personal exposure to DFV, and preparedness for clinical care of survivor women including identification and intervention. This Chapter includes the second publication of this thesis, '*Is a clinician's personal history of domestic violence associated with their clinical care of patients?* A cross-sectional study'.

Chapter 6 – Hospital workplace responses study. This Chapter is an exploration of the support needs that survivor health professionals have of their hospital workplace. The Chapter considers the role that hospital managers believe their organisation should play in responding to staff survivors and presents the third publication of this thesis: '*Hospital responses to employees who have experienced domestic violence:* A qualitative study with survivor health professionals and hospital managers'.

PART III – DISCUSSION & CONCLUSIONS (CHAPTERS 7-8)

Chapter 7 – Discussion. This Chapter discusses the research findings, synthesising them within the broader literature context.

Chapter 8 – Implications and Conclusion. This final Chapter begins with a presentation of the strengths and limitations of this PhD research. The critical conclusions to emerge from the thesis are summarised, and the implications for policy and practice explored. In closing, an argument is mounted for the direction of future research.

Following Chapter 8 is the Bibliography and Appendices.

1.7 CONCLUSION

Although health professionals as survivors of DFV have been the focus of a handful of studies during the last twenty-five years, findings have varied considerably, as has methodological rigour, and none have been local to Australia. Furthermore, extensive research into the barriers and enablers of health professional readiness to respond to DFV, some of which has indicated that lived experience of DFV may be a factor, has not clarified whether personal DFV exposure is associated with health professionals' clinical care of survivor women. Finally, no studies have explored the role of a hospital workplace in responding to staff survivors of DFV. This Introductory Chapter has briefly outlined the field of research within which this thesis seeks to contribute substantial new knowledge about the prevalence, impacts and implications of DFV against Australian health professional women. Language used throughout the thesis was clarified and the PhD Candidate author positioned. The next Chapter, the Literature Review, presents a thorough investigation of the evidence introduced in this Chapter.

2.

Review of the Literature

“As someone who has experienced and survived domestic violence, I am actually very 'grateful' that I have had that experience as I hope that it has given me a greater level of empathy for team members experiencing this or other challenges. I would like to see more openness about the number of current staff impacted by violence as I believe that would go some way to dispel many of the myths of family violence, e.g. it doesn't happen, I would just leave, etc. It is so much more complex than that!!”

(Survivor health professional participant)

“As an employer, I haven't dealt with domestic violence with my staff unless they've come to see me about it. But I haven't put the feelers out there and said, this could be an issue for us. Why wouldn't it be?”

(Hospital manager participant)

2.1 OVERVIEW

Violence against women is prevalent and harmful, with domestic and family violence (DFV) a leading contributor to poor health and a major reason women access health services (Australian Institute of Health and Welfare, 2018). Within health services, it is the job of health professionals to respond to the health needs of their survivor patients (García-Moreno et al., 2015). Those health professionals are most often women and may themselves have experienced DFV (Australian Institute of Health and Welfare, 2016b; Bracken et al., 2010). It is the intersection of women as both survivors *and* health professionals that is the concern of this thesis. In this literature review, DFV and the role of the mainly female health professionals at the frontline of identifying and responding to survivor women is described. The prevalence of DFV against health professional women and whether there is an association between DFV exposure and clinical care of survivors is examined comprehensively, following Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009). After this, a narrative review of the literature is applied to the role of the healthcare workplace in responding to the needs of survivor employees. This Chapter ends by establishing a rationale for this thesis having summarised the gaps in current knowledge and argued how this research will address what remains unknown.

2.2 BACKGROUND

2.2.1 Domestic & family violence

DFV is dangerous and widespread; a terrifying aspect of women's lives that comprises a major health burden to the individual and the broader community (Australian Institute of Health and Welfare, 2018). Hague and Bridge (2008, p. 185) describe DFV as being, "at the sharp end of gender oppression". The stark evidence is that the majority of DFV survivors in Australia and internationally are women (Australian Institute of Health and Welfare, 2018). Global estimates demonstrate the high prevalence of physical, sexual and emotional abuse (World Health Organization, 2013), which affects between 4% to 75% of ever-partnered women across their lifetime (World Health Organization, 2012). Australia's IPV prevalence is located at the lower end of the international spectrum, with 25% of adult women in a national survey self-reporting one or more incidents of partner violence since the age of 15 years, and 2.1% having experienced physical or sexual partner violence in the previous 12-months (Australian Bureau of Statistics, 2017). This figure includes both women who have experienced a sustained pattern of violence and those whose abusive experiences have been sporadic (Cox, 2015). This definition of relationships is broad; it includes cohabitating partners as well as boyfriends and dating relationships (Cox, 2015). For one in two incidents of sexual assault, the perpetrator is a male partner, and across the Australian community, 18% of adult women are affected in their lifetime (Australian Institute of Health and Welfare, 2018; Australian Institute of Health Welfare, 2019). The national prevalence of physical and sexual violence before the age of fifteen is 16%, and this violence predominantly occurs within the family of origin (Australian Bureau of Statistics, 2017). In homes where there is violence, children often bear it witness - half of all women experiencing current IPV, and two-thirds who have had a previous violent relationship, report their children seeing or hearing the abuse (Australian Bureau of Statistics, 2017).

Many factors contribute to DFV but chief among them is the power disparity between men and women as a result of women's relative lack of access to resources and rigid gender roles, including concepts linking masculinity with dominance (Flood & Pease, 2009; Heise, 1998; Our Watch & VicHealth, 2015). DFV is complicated; both men and women can display aggression towards their partner, and in relationships where there is violence it is not uncommon for both partners to report the experience of intimidating and abusive tactics from the other (Walby & Allen, 2004). However, the level of fear that women and men in an abusive relationship experience - and the harm caused - is asymmetrical (Indermaur, 2001). Women are much more likely to report feeling "terror" of a male partner, given the physical and non-physical power differences between them (Indermaur, 2001, p. 4; Kertesz et al., 2019). Relationship violence usually occurs along a continuum, rather than being an isolated incident (Howarth, Stimpson, Barran, & Robinson, 2009). It is something a woman may endure long-term, often escalating if she ends the relationship (Howarth et al., 2009). Belonging to some cultures and religions can make leaving a violent relationship, or accessing resources to increase protectiveness against violence, especially difficult (Gill, 2004). This includes in communities where members carry the responsibility of protecting their minority culture in the face of external hostility from the broader society or from other groups (Gill, 2004).

In Australia, most homicides are perpetrated by men who have killed their female partner (Australian Bureau of Statistics, 2017; García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Virueda & Payne, 2010). Of the proportionally few cases where women have killed their male partner, there is usually overwhelming evidence of prior violence against that woman by the male partner in the form of ongoing severe physical and sexual assaults (Victorian Law Reform Commission, 2004). Despite the high DFV prevalence that population studies have uncovered, it is widely agreed that statistics probably underrepresent the real occurrence of DFV in the community because of the many factors women negotiate when considering whether to report, including fear of reprisal and shame (Fanslow & Robinson, 2011; Krug et al., 2002; VicHealth, 2011).

Aboriginal women and children experience the highest rates of DFV in Australia (Australian Institute of Health and Welfare, 2018). This violence sits within a historical context of white settlement and colonisation and consequent impacts including cultural dispossession, forced removal of children, rupture of kinship systems and cultural law, systemic racism, social and economic exclusion, and trans-generational grief and trauma (Aboriginal Affairs Victoria, 2008). Women who live with a disability, women who live in remote areas and women from culturally and linguistically diverse backgrounds are also likely to experience higher rates of violence than other women (Australian Institute of Health and Welfare, 2018).

2.2.2 The multifaceted impacts of DFV

Social impacts

DFV impacts upon many aspects of individual, family and social life, including housing, employment and the economy (Krug, Dahlberg, Mercy & Lozano, 2002). It is estimated that DFV costs the Australian economy $13.6 billion a year, with employers' footing $235 million of the bill (Price Waterhouse Coopers, 2015). $10.4 billion of the overall cost is attributed to physical and psychological pain, suffering and premature mortality (Price Waterhouse Coopers, 2015). While substance abuse and mental health issues often cause men's homelessness, women's homelessness is more commonly a result of DFV (Australian Institute of Health and Welfare, 2011). Women in an abusive relationship are more likely to report being socially isolated and impoverished (Australian Institute of Health and Welfare, 2011; Krug, et al., 2002).

Physical & psychological health impacts

On just about any health indicator, women who have experienced violence and abuse from their partner fair worse than women who have not (Black, 2011; Trevillion, Oram, Feder, & Howard, 2012; World Health Organization, 2013). Representing more than 3.3% of the national disease burden shouldered by women aged 25-44 years, DFV doubles survivor's health service use, harms their children and leads to poorer mental health, including anxiety, depression and post-traumatic stress (Ayre, Lum On, Webster, Gourley, & Moon, 2016; Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Kessler et al., 2002; Lacey, McPherson, Samuel, Sears, & Head, 2013; Rees et al., 2011; Spangaro, Zwi, Poulos, & Man, 2010a; Thompson et al., 2006; Trevillion et al., 2012). DFV can also lead to physical health problems, including chronic pain and disease (Ayre et al., 2016; Black, 2011; Campbell, 2002; Coker et al., 2002; Dillon, Hussain, & Loxton, 2015; Ellsberg et al., 2008). Research suggests that the antenatal period may be a time of increased risk of violence commencement or escalation (Burch & Gallup, 2004; Campo, 2015; Howell, Miller-Graff, Hasselle, & Scrafford, 2017; Martin et al., 2004; Mezey et al., 2003; World Health Organization, 2011). Hospital injury data indicates that the pelvic area may be a target of physical assaults during pregnancy, compared to other times (Cassell & Clapperton, 2015). DFV is correlated with unwanted pregnancy, miscarriage and abortion and has been linked with preterm birth, small for gestation age and low birth weight infants (Donovan, Spracklen, Schweizer, Ryckman, & Saftlasa, 2016; Hall, Chappell, Parnell, Seed, & Bewley, 2014; World Health Organization, 2011).

Women who have experienced sexual assault wear its impacts through the undermining of their mental health, including increased rates of depression, anxiety, self-harm and substance use (Australian Institute of Health and Welfare, 2018). There are employment impacts from sexual assault too, including difficulty maintaining work due to extended leave, psychological health impacts and poor workplace support (Walden & McFerran, 2014).

The employment impacts of DFV

Employment can be an asset for survivors who have experienced DFV but impacts from DFV also place a survivor's employment at risk (Rayner-Thomas, Fanslow, & Dixon, 2014). The effects of DFV on the workplace can be direct or indirect (Yragui, Mankowski, Perrin, & Glass, 2012). Direct effects include a perpetrator threatening a woman at work or keeping her from attending (Brush, 2002). Indirect effects may be increased absenteeism, impacted work performance, or feelings of anxiety and depression at work (Riger, Ahrens, & Blickenstaff, 2000; Swanberg & Logan, 2005). Employment affords social support, financial resources and increased exit options out of violence (Blustein, 2008; Falk, Shepard, & Elliott, 2001; Felblinger & Gates, 2008; Pollack et al., 2010; Rothman, Hathaway, Stidsen, & de Vries, 2007). However, DFV also contributes to job instability, which is, in turn, associated with higher rates of depression and anxiety (Adams, Bybee, Tolman, Sullivan, & Kennedy, 2013). Further, as a site of employment for health professionals and others, hospitals confront a high volume of occupational abuse and aggression from patients, visitors and colleagues (Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017). In fact, research suggests that the health sector may be the most violent employment industry for Australian women because of the prevalence of occupational violence from patients (Perrone, 1999; Shea et al., 2017).

2.2.3 The role of health professionals in responding to survivors

The profound effect that DFV has on the health and wellbeing of survivors designates the health system as ideally positioned to identify survivors and respond with a focus on safety and healing (García-Moreno et al., 2015). Some survivor women will never contact a specialist DFV service, but many will seek medical care at different times in their lives, including to access treatment for the physical and psychological impacts of violence (State of Victoria, 2014-16). For decades, State and National plans in Australia have specified a specific and vital role for health professionals and the healthcare sector (Commonwealth of Australia, 2019). However, there are many barriers to the uptake and embedding of DFV clinical care within the health system, including at the points of identification and response.

Identification

In order to assist women at risk of, or experiencing DFV, health services must first identify them. Women who have experienced DFV access healthcare services more frequently than other women, although most often DFV is not their presenting complaint (Feder et al., 2009). Research shows that generally, women do not mind being asked about their experience of violence and may identify enquiry as a protective intervention in itself (Feder et al., 2009; Rivas et al., 2015). Survivors commonly name health professionals among the people with whom they would feel most comfortable to discuss DFV (Feder, Hutson, Ramsay, & Taket, 2006; World Health Organization, 2013). However, in the absence of direct questioning, women may be unlikely to reveal their abuse history and clinicians may be unaware that the patient before them has experienced DFV (Rhodes et al., 2011; World Health Organization, 2013).

In the last two decades, there have been upwards of five systematic reviews into the efficacy of DFV identification or "screening" (Feder et al., 2009; Nelson, Bougatsos, & Blazina, 2012; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; O'Doherty et al., 2014; Ramsay, Richardson, Carter, Davidson, & Feder, 2002). Screening is often defined as asking all women about DFV according to a procedure, regardless of indicators or organisational factors (i.e. resources). The most recent review did not support DFV screening in healthcare (O'Doherty et al., 2014). While screening is likely to increase identification, and does not appear to cause harm, the evidence from this review was that screening did not translate into increased referrals to specialist DFV services, or, most importantly, lessen violence in survivors' lives (O'Doherty et al., 2014). For that reason, DFV screening in healthcare is not endorsed by the World Health Organization (World Health Organization, 2014). Unlike other health issues for which screening has a long and successful history, by its nature, DFV is a complex social issue, not a disease (O'Doherty et al., 2014). Implementing screening is a tricky business; multiple barriers stand in the way (Sprague et al., 2012). Obstacles include inadequate preparation, training and support for staff to screen, resource-poor health settings that inadequately follow-up and refer survivor patients, as well as health professional concerns including misconceptions about DFV, discomfort with the issue and, perhaps, personal experience of DFV (Sprague et al., 2012). For screening to be effective and efficient, barriers need to be overcome, and staff training, access to specific resources and survivor follow-up, among other hospital factors and processes, need to come together (Gomez-Fernandez et al., 2019). Rather than a policy of screening, the weight of evidence favours training health professionals to identify indicators and impacts of DFV, building confidence to discuss DFV with women and encouraging a low threshold for DFV enquiry (O'Doherty et al., 2014; World Health Organization, 2014). Despite the evidence, legislated screening is not uncommon. It was recently introduced into maternity hospitals in Victoria, Australia, where pregnancy risk, clinical engagement and policy timing collided in the wake of the Royal Commission into Family Violence (State of Victoria, 2014-16). Other Australian States and Territories have had mandatory DFV screening in specific health settings for some time (Spangaro, Zwi, Poulos, & Man, 2010b). Across the developed world, screening is legislated in some settings, but not others (O'Doherty et al., 2014).

Response

No matter how it is that a woman who has experienced DFV is identified, there is broad agreement about the components of an effective health professional response towards her (World Health Organization, 2013). Non-intrusive initial support is recommended that responds to the woman’s practical, emotional, physical, safety and support needs (World Health Organization, 2014). This type of response includes demonstrating belief and empathy, exploration of the woman’s situation with a focus on risk and protective factors, understanding and validating that the violence may be impacting upon the woman in harmful ways, reassuring against blame, the offer of practical care and support that is not intrusive of autonomy, and connection with longer-term services and resources (García-Moreno et al., 2015; Parker, McFarlane, Soeken, Silva, & Reel, 1999; Ramsay et al., 2009; Rivas et al., 2015; Tiwari et al., 2005; World Health Organization, 2013, 2014). The World Health Organization (2014) LIVES model exemplifies a best practice first-line DFV health professional response (Table 1).

Table 1. First-line support: LIVES model (WHO, 2014)

Listen	Empathetically listen to the woman, without judgement
Inquire	Ask about the woman's practical, emotional, physical and social needs
Validate	Show the woman that you believe her and reassure against self-blame
Enhance safety	Explore safety options and establish a safety plan together
Support	Work with the woman to connect her to support, information and services

In the first of two Cochrane Reviews evaluating clinical trials into the effectiveness of counselling and advocacy provided by specialist DFV services and less intensive DFV interventions delivered in healthcare settings, some reduction in harm was identified one to two years post-intervention for women accessing specialist DFV services and refuges (Ramsay et al., 2009). However, the evidence did not sufficiently demonstrate harm reduction or improvement to survivor wellbeing or functioning when the intervention was delivered within a healthcare setting (Ramsay et al., 2009). The second of these reviews, a systematic review of quantitative studies into the efficacy of DFV interventions, found equivocal evidence about the effectiveness of interventions to reduce or stop DFV (Rivas et al., 2015). Most recently, a systematic review of IPV interventions delivered across a range of settings found they were associated with better mental health and increased social support for survivors but not violence reduction or increased healthcare utilisation (Ogbe, Harmon, Van den Bergh, & Degomme, 2020). Survivors' may be left feeling helpless and isolated if they present to a health service with indicators of abuse that are missed or interpreted as physical or psychological symptoms (Warshaw, 1989; World Health Organization, 2013). Health services are rapidly trying to develop their policies, health professional training and patient resources as they recognise, or are mandated to prepare for, a more comprehensive role working with women and their children towards safety and recovery (State of Victoria, 2014-16; World Health Organization, 2014, 2016). Health services appear to have approached this more comprehensive role, however, in the absence of meaningful consultation with women with lived experience.

2.2.4 Consultation with those who have lived experience

Health services, along with other mainstream services, have long been vulnerable to valid criticism for not meaningfully consulting with women with lived experience of DFV (also known as ‘experts by experience’) about the way their service operates (Hague & Mullender, 2006). Without consultation with survivors about their needs and experiences, a service is unlikely to be responsive enough to the survivors who access it (Boyle, Coote, Sherwood, & Slay, 2013; Hague & Mullender, 2006). Consultation, of course, is just the start of service user involvement; on a continuum with consultation at one end, there is a long way to go before those with lived experience are co-producing services with a share in real decision-making power, able to hold services accountable (Hague & Mullender, 2006; Werner-Seidler & Shaw, 2019). Service user participation appears to be a common discourse within policy; “customer satisfaction” is almost ubiquitous in the general and corporate service sectors, and the consumer advocacy movement in health, mental health and Aboriginal services is well under way (Beaumont, 2019; Clayson, Webb, & Cox, 2018; Scholz et al., 2019). However, there is little evidence that meaningful consultation with women who have experienced DFV is being used to structurally inform hospital responses to DFV in Australia. For example, despite significant exploration about the role of the health system in responding to DFV in the recent Royal Commission into Family Violence (2014-2016), and a long list of recommendations specifying “system-wide reform” across the health care sector, not one pertained to consultation with women with lived experience (State of Victoria, 2014-16). This may change, however, with the 2016 creation of the ‘Victim Survivors’ Advisory Council’; a group of survivors whose role is to provide consultation to the Victorian Government about the State-wide, multi-sector DFV reform agenda recommended by the Royal Commission into Family Violence (State Government of Victoria, 2020; State of Victoria, 2014-16).

Many reasons may contribute to this lack of survivor consultation, not least of which is the demand-driven nature of health services, where things are continually added to the clinical plate, but never taken off. Nevertheless, a critical difference between the health and mental health sectors in Australia that may help explain the historical divide with reference to service-user consultation, advocacy, co-production and co-design, is the recovery-orientated approach that underpins mental health care (Department of Health and Human Services, 2019). The approach in the Australian mental health sector seeks to move beyond the treatment of disease towards personal, mental health and wellbeing recovery, a pursuit that is reinforced through consumer engagement (Department of Health and Human Services, 2019; Foglieni, Segato, Sangiorgi, & Carrera, 2019). While survivor participation may not yet be informing the general health system response to DFV, there is little doubt that considerable efforts over some time have gone into strengthening the capacity of health services to identify early and respond sensitively to women who have experienced DFV and critical to this is confronting barriers (Commonwealth of Australia, 2019; Strengthening Hospital Responses to Family Violence, 2019; World Health Organization, 2016).

2.2.5 Barriers to providing DFV clinical care

For almost as long as health services have been trying to increase the capacity of their staff to respond to survivor women, there has been research investigating barriers and facilitators to staff readiness. Barriers to health professional engagement with women about their experience of DFV include: clinician lack of knowledge; training; time, fear of causing offence; discomfort; feeling pushed into a ‘social’ role for which the health professional does not have expertise; and frustration based on perceptions about survivor decisions (Spangaro et al., 2011; Sprague et al., 2012; State of Victoria, 2014-16; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Unlike a health condition that comes with a screening tool, a prescription pad and bandages, DFV is both socially constructed and interpreted (VicHealth, 2014). Health professionals are members of the same community where misconceptions abound that privatise DFV as a family issue; excuse or erase men’s violence; and blame, discredit or disbelieve women’s experience (Bhandari et al., 2008; Webster et al., 2018).

Clinician’s personal experiences of DFV may be yet another impediment to professional engagement with DFV patient practice (Beynon et al., 2012; Mezey et al., 2003; Sugg & Inui, 1992). Some research has found personal experience of DFV might inhibit DFV enquiry, identification and clinical care of women (Mezey et al., 2003), while other research has suggested it might be an enabler of good DFV practice (Beynon et al., 2012). For example, a qualitative study by Mezey et al. (2003) found that some midwives who had personally experienced DFV described it as a facilitator to routine enquiry with women sometimes, but at other times, they experienced it as a barrier to their ability to provide clinical care to survivors. Since most health professions are female-dominated and given the established high prevalence of DFV in the general community, DFV against health professional women is an issue that demands closer inspection, and it is in this direction that the review will now pivot (Australian Institute of Health and Welfare, 2013b).

2.3 LITERATURE SEARCH

To review evidence in the field of health professionals, personal DFV experience and related impacts, two comprehensive reviews of the literature were undertaken to answer the following two research questions:

1. *What is the prevalence of domestic and family violence against health professionals?* and,
2. *Does personal exposure to domestic and family violence influence clinical care of survivor women?*

2.3.1 Rationale

To answer the research questions, this literature review followed PRISMA guidelines (Moher et al., 2009). These evidence-based guidelines are a minimum set of items for reporting both observational studies and systematic reviews (Lasserson, Thomas, & Higgins, 2019).

2.3.2 Strategy

On 22 September 2017, a search of the PsychInfo, PubMed/Medline, Cinahl and the Cochrane Library databases was conducted. This process was repeated in 2019 (uncovering an additional relevant paper). Databases were selected with advice from a health librarian for their health and human experience span. A twenty-five-year limit was placed on publication date to reflect contemporary practice. No specific search software was used. Medical subject headings (MeSH) and keywords differentiating four distinct thematic concepts (*domestic and family violence, health profession, experience* and *prevalence*) were used to find relevant articles across the four databases. The search strategy for research questions one and two involved multiple keyword searches using the terms in Table 2:

Table 2. Literature search terms

Keyword	Concept 1	Concept 2	Concept 3	Concept 4
Synonyms/Related words	Domestic violence	Health professional	Personal experience	Prevalence
	Family violence	Health personnel	Life experience/ experiences	
	Intimate partner violence	Health care provider	Personal history	
	Partner abuse	Health worker	Victimi$ation/victim history (victim*)	
	Spouse/spousal abuse (spous* abuse)	Helping professional	Events	
	Battered/battering (batter*)	Nurse/nursing (nurs*)		
	Sexual abuse	Midwife/midwifery (midwif*)		
	Sexual assault	Doctor		
	Violence against women	Physician		
	Intimate/partner terror	Medical personnel		
	Intimate violence victim	Allied health personnel / professional		
	Child abuse	Psychologist		
	Dating violence	Physiotherapist		
		Occupational therap*		
		Social work*		
		Clinician		

2.3.3 Study selection

Publications identified from the literature search were screened for duplicates. All titles and abstracts were reviewed, and potentially relevant articles were chosen for full-text appraisal. A selection of abstracts was screened by both PhD supervisors to ensure consistency. Studies were considered for inclusion in the literature review if they met the criteria set out in Table 3. The citation lists of relevant papers were hand-searched and additional pertinent articles retrieved this way. All selected full-text papers were read by both PhD supervisors.

Table 3. Study selection inclusion & exclusion criteria

Inclusion criteria	Exclusion criteria
An original, peer-reviewed observational (cross-sectional) study	Health professional student participants were excluded since the focus of this study was on health professionals who had completed their tertiary training and had graduate experience of clinical work
Investigation of DFV prevalence against nurses, doctors, social workers and other allied health professionals employed in a healthcare setting	Studies where childhood violence and abuse were the only topic investigated were excluded given the focus of this study included, but was not specific to, childhood abuse and witnessing
Survivor health professionals were categorised as having primary not secondary (i.e. survivor family / friends / others) exposure to DFV, or primary and secondary exposure was separated in the analysis	Workplace harassment or abuse as the only topic of study given the focus of this research was on DFV
Study was published in English due to the lack of translation resources	Studies where primary and secondary DFV exposure was not separated in the analysis since it can be assumed that all health professionals have had secondary exposure to DFV
	Methods that were primarily qualitative
	Grey literature

2.3.4 Results

Results from Search Strategy One of the academic literature (1987– 2017, updated in 2019) are summarised in Figure 1 with 864 publications identified. Of those, 154 were duplicates between the three databases, and an additional 370 were excluded after reviewing their title because they did not meet *a priori* criteria. The remaining 340 article abstracts were read, which excluded a further 297 publications. Hand searching the reference lists yielded four additional studies for inclusion. The remaining 47 papers were read in full, leading to 32 exclusions. The three most common reasons for exclusion were that the paper was not inclusive of DFV (e.g. the focus was on child abuse before 18 years of age), participants were not qualified health professionals (e.g. therapists in private counselling practice) or DFV survivors were defined as having secondary, but not primary, exposure to DFV (e.g. they were family/friends of survivors). At the end of this funnelling process, 15 unique articles met the inclusion criteria. These included studies were compared to determine their similarities and differences in relation to the type of violence investigated, the health professional background of participants, the measures used, whether outcomes were gendered, and how prevalence rates compared to the general population. All studies were included regardless of their perceived quality or limitations. The heterogeneity of the studies prevented the possibility of statistical analyses to synthesise, compare and contrast. Instead, narrative descriptions of the studies are provided.

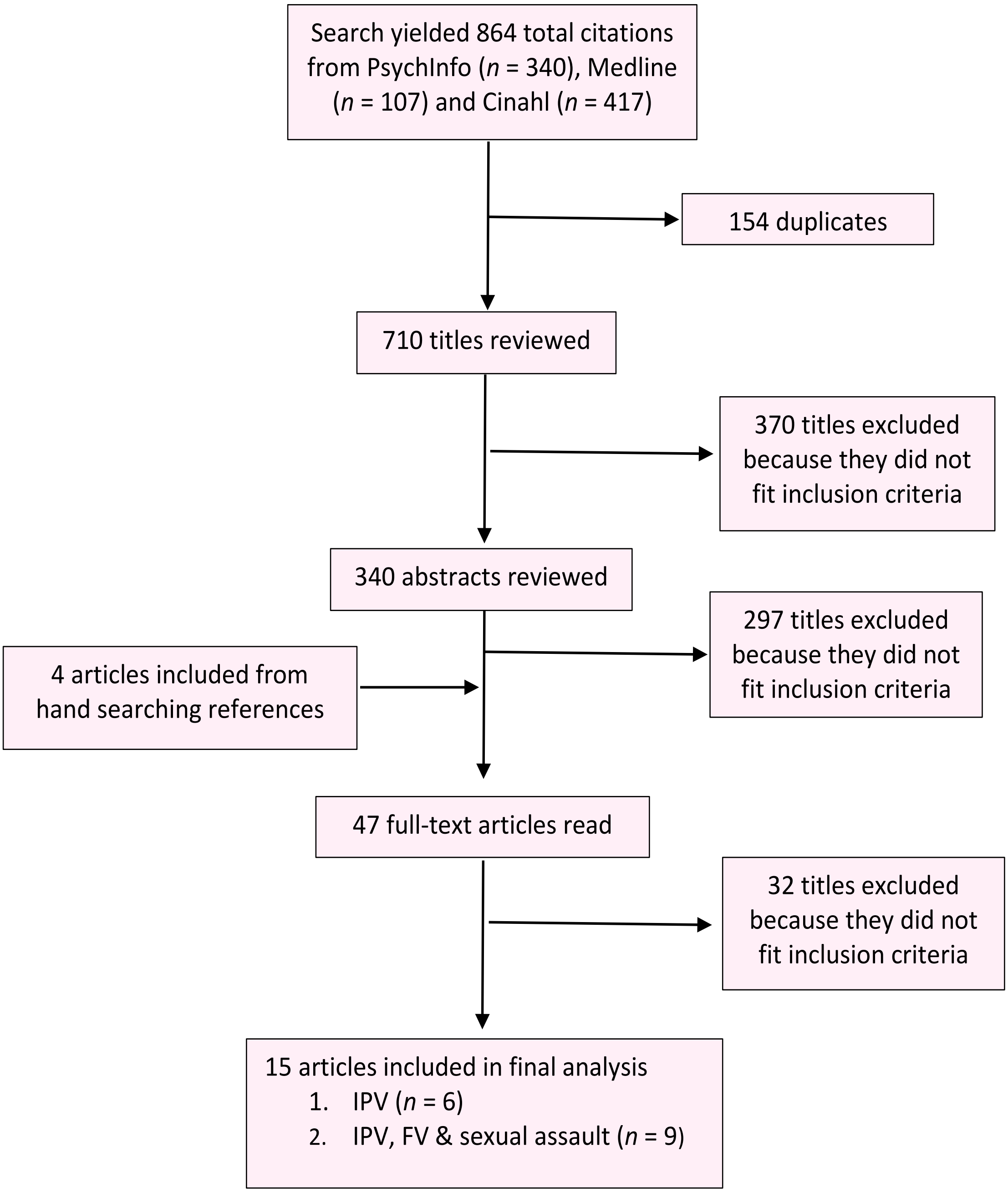

Figure 1. Search strategy flow diagram

2.4 ANALYSIS OF THE EVIDENCE BASE

2.4.1 Study characteristics

The fifteen included studies comprised a total of 13,439 participants and identified an adult lifetime prevalence rate of between 3.7% (‘domestic violence’ against doctors in the USA) to 51.4% (‘intimate partner violence’ against nurses in Guyana) (Al-Natour et al., 2014; Bracken et al., 2010; Candib et al., 2012; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Diaz-Olavarrieta, Paz, de la Cadena, & Campbell, 2001; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Khan, Karmaliani, Saeed Ali, Asad, & Madhani, 2014; Mitchell et al., 2013; Rodriguez et al., 1999; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). A feature of these studies was their diversity: they arose from 10 countries across five continents, with six from countries that are faced with significant social and economic challenges, conducted in languages other than English (Al-Natour et al., 2014; Christofides & Silo, 2005; Diaz-Olavarrieta et al., 2001; Khan et al., 2014; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). None of the 15 included studies was Australian. Only three studies investigated the prevalence of 12-month DFV (Bracken et al., 2010; Cavell Nurses' Trust, 2016; Sharma & Vatsa, 2011), the rest inquired about longer time periods. Six studies were of adult IPV (Al-Natour et al., 2014; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; Early & Williams, 2002; Janssen et al., 1998; Mitchell et al., 2013), while nine were of lifetime DFV, including sexual assault and childhood witnessing (Bracken et al., 2010; Candib et al., 2012; deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Khan et al., 2014; Rodriguez et al., 1999; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). The included studies are summarised in Table 4.

Table 4. Characteristics of studies included in the literature review

Study	**Sample (% response rate)**	**Participants**	**Setting**	**Cross-sectional survey design**	**Relevant outcomes measures**	**DFV measure**	**Findings (female participants only)**	**Strengths | Limitations**
Cavell Nurses' Trust (2016) UK	*N* = 2254 (?<1%)	Female (*n* = 1546) & male (*n* = 100) nurses & healthcare assistants	Nursing Union	Online	12-mth IPV prevalence of non-physical abuse as well as threats, force and injury. Part of larger survey about health & social issues	4-items from the *Partner Abuse Module* of the Crime Survey for England and Wales (CSEW) (2018-19)	Higher 12-mth IPV prevalence than general population: - 14.0% combined non-physical, threat or force - 12.1% non-physical abuse (4 x higher than community) - 4.4% threat of violence - 3.1% physical violence (2-3 x higher than community)	- Convenience sample - Utilisation of national population prevalence (behavioural) measure - Large sized sample (75th percentile of all studies in the field) - Likely low response rate (<1%) (unpublished)
Al-Natour et al. (2014) Jordan	*N* = 80 (~60%)	Female nurses	x10 health centres & x3 hospitals	Paper	Lifetime psychological, physical and sexual IPV against nurses compared to community prevalence	Women Abuse Screening Tool (WAST) (7 items) (Brown, Lent, Brett, Sas, & Pederson, 1996) (translated into Arabic)	Comparable lifetime IPV prevalence to general population: - 59% psychological abuse - 12.5% physical abuse - 5.1% sexual abuse	- Random sample - Validated (behavioural) prevalence measure - 12-mth prevalence not measured raising recall demands - Small sized sample (25th percentile of all studies in the field) - Response rate >50% - Non-English speaking, non-Western country - Only married women surveyed

Khan et al. (2014) Pakistan	*N* = 350 (75%)	Female nurses & doctors	x3 hospitals	Paper	Lifetime prevalence of emotional/psychological IPV	Abridged version of the World Health Organization Study of Domestic Violence and Women's Health (WHO MCS) (García-Moreno et al., 2005) Unclear number of abuse items in survey	Higher lifetime emotional/psychological IPV prevalence than general population (70-90%): - 97.7% lifetime exposure to some form of IPV - 62.6% emotional abuse - Nurses had higher prevalence than doctors	- Convenience sample - Use of truncated validated (behavioural) prevalence measure (emotional and psychological items alone) - 12-mth prevalence not measured raising recall demands - Medium sized sample (50th percentile of all studies in this field) - Response rate >50% - Non-English speaking, non-Western country - Only ever-married women surveyed
Mitchell et al. (2013) Guyana	*N* = 363 (87.4%)	Female (*n*= 297) & male (*n*=48) nurses	Hospital	Paper	Lifetime prevalence of physical & emotional IPV & DFV victimisation & perpetration Part of larger 30-item survey about attitudes	Bespoke 3-items comprising abridged WHO MCS (García-Moreno et al., 2005) and Abuse Assessment Screen (AAS) (McFarlane, Parker, Soeken, & Bullock, 1992)	Likely higher lifetime IPV prevalence than general population (?33%): - 51.4% lifetime exposure to (any) IPV victimisation	- Convenience sample - 3-items derived from two different validated (behavioural) measures - 12-mth prevalence not measured raising recall demands - Medium sized sample (50th percentile of all studies in this field) - Response rate >50% - Small (750,000), non-Western country

Candib et al. (2012) USA	*N* = 380 (45.5%)	Female (*n* = 151) & male (*n* = 144) physicians	Family practice	Paper	Lifetime prevalence of physical & sexual abuse in childhood by anyone, DFV witnessing in childhood, adult physical assault by intimate partner & adult sexual assault by anyone Part of larger survey including about child abuse screening practices	Bespoke 5-items about child abuse (3), sexual abuse (1) & IPV (1)	Lower lifetime IPV prevalence compared to general population (25%): - 15.9% lifetime exposure to some form of IPV - 26.5% lifetime exposure to child abuse (incl. witnessing) - 27.2% lifetime exposure to sexual abuse by anyone	- Convenience sample - Bespoke (behavioural, not validated) measure of IPV & DFV - 12-mth prevalence not measured raising recall demands - Response rate <50% - Medium sized sample (50th percentile of all studies in this field) - IPV, DFV prevalence not the focus of this study

Sharma and Vatsa (2011) India	*N* = 60 (5.2%)	Female nurses	Hospital	Paper	12-mth & lifetime physical, sexual & psychological prevalence, characteristics & impact of IPV Part of larger study including attitudes	WHO MCS (García-Moreno et al., 2005). Unclear number of abuse items in survey	Comparable lifetime IPV prevalence to general population (18-70%): - 16.7% 12-mth sexual IPV - 35.0% 12-mth physical IPV - 48.3% 12-mth emotional IPV - 75% lifetime combined IPV (50% physical/sexual) - 65% lifetime emotional IPV - 43.3% lifetime physical IPV - 30% lifetime sexual IPV	- Convenience sample - Validated (behavioural) prevalence measure - Small pilot study (sample size in the 25th percentile of all studies in this field) (no larger study located) - Low response rate (<10%) - Non-English speaking, non-Western country - Only married women surveyed

Bracken et al. (2010) USA	*N* = 1981 (52%)	Female nurses & nursing personnel	x3 hospitals & x1 aged care centre	Online	12-mth & lifetime prevalence of physical & sexual IPV & DFV witnessing in childhood Part of larger study about workplace violence	Bespoke 7-items about IPV & DFV prevalence	Comparable lifetime IPV prevalence to general population (25-30%): - 1.5% 12-mth physical IPV - 0.6% 12-mth sexual IPV - 2.4% 12-mth emotional IPV - 23.9% lifetime exposure to IPV or DFV (any) - 25% lifetime physical or sexual IPV - 22.8% lifetime emotional IPV - 13.3% childhood physical or sexual abuse - 10.6% witnessing	- Convenience sample - Bespoke (behavioural & non-behavioural) measure - Large sized sample (75th percentile of all studies in this field) - Response rate >50%

Stenson and Heimer (2008) Sweden	*N* = 588 (68%)	Female nurses, doctors & allied health professionals	Hospital	Paper	Lifetime prevalence of emotional, physical & sexual abuse by partner or anyone, & DFV witnessing in childhood. Primary & secondary exposure to IPV & impact on practice Part of larger survey about practice & knowledge	NorVold Abuse Questionnaire (Swahnberg & Wijma, 2003) 10-items	Comparable lifetime IPV prevalence to general population (19.7%). (All % denote primary exposure): - 23.5% lifetime IPV (any) (primary exposure) - 16.5 lifetime physical IPV - 6.5% lifetime sexual IPV - 14.0% lifetime emotional IPV - 6.1% witnessing - 22.1% secondary exposure (alone)	- Random sample - Validated (behavioural) prevalence measure - 12-mth prevalence not measured raising recall demands - High response rate >50% - Large sized sample (75th percentile of all studies in this field) - Non-English-speaking country
Christofides and Silo (2005) South Africa	*N* = 212 (52%)	Female nurses	Primary Care	Paper survey delivered face-to-face	Lifetime physical & emotional IPV. Primary & secondary exposure to IPV & impact on practice	WHO MCS (García-Moreno et al., 2005). Unclear number of abuse items in survey	Comparable lifetime IPV prevalence to general population (25% physical, 50% physical or sexual). (All % denote primary exposure): - 39.0% lifetime IPV (any) - 14.6% lifetime physical IPV - 37.7% lifetime emotional IPV - 41.0% secondary exposure (alone)	- Convenience sample - Validated (behavioural) prevalence measure - 12-mth prevalence not measured raising recall demands - Response rate >50% - Medium sized sample (50th percentile of all studies in this field) - Non-English-speaking country - Lack of confidentiality given the delivery of the measure may have influenced disclosure

Early and Williams (2002) USA	*N* = 195 (?%)	Female (*n* = 160) & male (*n* = 35) nurses	Hospital emergency department	Paper	Lifetime prevalence of physical IPV victimisation & perpetration Part of larger study about effect on nurses' care of survivor patients	Bespoke 1-item	Comparability to general population prevalence not stated & unable to be inferred. Female & male results not separated in analysis: - 40% lifetime experience of victimisation (physical IPV) - 19% lifetime experience of perpetration (physical IPV) - 70% lifetime experience of being assaulted by patient	- Convenience sample - One bespoke (behavioural) item to measure prevalence - 12-mth prevalence not measured raising recall demands - Medium sized sample (50th percentile of all studies in this field) - Unpublished response rate - Male & female data not separated in results - Equal emphasis on experience of IPV, patient victimisation & perpetration
Diaz-Olavarrieta et al. (2001) Mexico	*N* = 1150 (~90%, inferred & unpublished)	Female nurses & nurses' aides	x6 public tertiary hospitals & x5 private hospitals	Paper	Lifetime prevalence of physical, sexual & emotional IPV & physical & emotional abuse in childhood Part of larger study to identify IPV risk factors	deLahunta and Tulsky (1996) 30-items	Lower lifetime prevalence compared with Mexican population (~30%): - 14% lifetime physical/sexual DFV - 40% lifetime emotional DFV - 14% physical/sexual childhood abuse	- Random sample - Validated (behavioural) measure - 12-mth prevalence not measured raising recall demands - Large sized sample (75th percentile of all studies in this field) - High response rate (~90%) - Reported 95% confidence intervals - Non-English-speaking country

Doyle et al. (1999) USA	N = 4501 (59%)	Female doctors	American Medical Association register	Paper	Lifetime prevalence of "*domestic violence*" & sexual assault Part of larger 41-item health screen in *Women Physicians' Health Study* (WPHS) Lifetime primary & secondary exposure (FV alone)	Bespoke 2-items	Lower lifetime prevalence compared with general population (21% Kentucky, 30% Texas): - 7.4% lifetime DFV, including sexual assault - 3.7% lifetime DFV - 4.7% lifetime sexual assault	- Stratified random sample - Bespoke (non-behavioural), two-item measure - 12-mth prevalence not measured raising recall demands - Large sized sample (75th percentile of all studies in this field) - Response rate >50% - Prevalence rate substantially lower than community
Rodríguez et al. (1999) USA	N = 400 (69%)	Male (n = ~240 unspecified) & female (n = ~160, unspecified) physicians	Californian Medical Association Database	Paper	Lifetime prevalence of physical IPV, fear & DFV witnessing in childhood Part of larger screening survey	Bespoke 2-items	Comparability to general population prevalence not stated & unable to be inferred: - 20% lifetime fear and/or physical abuse from a partner - 15% childhood witnessing parental IPV	- Stratified probability sample - Bespoke (behavioural), two-item measure - Medium sized sample (50th percentile of all studies in this field) - Response rate >50% - DFV prevalence not the focus of this study about screening practice

Janssen et al. (1998) Canada	*N* = 198 (99.5%)	Female nurses	Maternity hospital	Paper	Lifetime prevalence of emotional, psychological, physical & sexual IPV	Bespoke 5-items developed to become part of the 3-item AAS (McFarlane et al., 1992)	Likely higher lifetime IPV prevalence than general population (29%): - 38% lifetime IPV (all) - 26.9% lifetime emotional IPV - 14.6% lifetime physical IPV - 8.1% lifetime sexual IPV	- Convenience sample - Bespoke 5-item measure that went on to be validated as the 3-item AAS. 3 of 5 items were behavioural - 12-mth prevalence not measured raising recall demands - Nearly universal response rate - Small sized sample (25th percentile of all studies in this field) - Early study in this field
deLahunta and Tulsky (1996) USA	*N* = 757 (69%)	Female (*n* = 293) & male (*n* = 482, 54%) doctors & medical students	University Medical Centre	Paper	Lifetime prevalence of physical & sexual IPV & physical & sexual abuse in childhood	Bespoke 30-items. 2 of 3 AAS items were adapted to include in this measure (McFarlane et al., 1992)	Comparable lifetime IPV prevalence to general population (25%): - 24.2% lifetime physical/sexual IPV - 22% physical/sexual child abuse - 40% combined adult IPV & child abuse	- Convenience sample - Bespoke measure - 6 of 8 IPV items were behavioural, while 2 of 8 child abuse items were not behavioural - 12-mth prevalence not measured raising recall demands - Large sized sample (75th percentile of all studies in this field) - Response rate >60% - First study in the field

2.4.2 Participants

Nine of the included studies sampled nurses and nursing assistants (Al-Natour et al., 2014; Bracken et al., 2010; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; Diaz-Olavarrieta et al., 2001; Early & Williams, 2002; Janssen et al., 1998; Mitchell et al., 2013; Sharma & Vatsa, 2011); four surveyed doctors (Candib et al., 2012; deLahunta & Tulsky, 1996; Doyle et al., 1999; Rodriguez et al., 1999); one included both nurses and doctors (Khan et al., 2014) and the remaining study comprised nurses, doctors and allied health professionals (Stenson & Heimer, 2008). These last two studies were the only ones to include more than one health professional group (Khan et al., 2014; Stenson & Heimer, 2008). Of these, there was no difference in violence prevalence between nurses, doctors and allied health professionals in the Stenson and Heimer (2008) study, however Khan et al. (2014) found female nurses had a higher prevalence of emotional IPV (57.9%) compared to female doctors (42.1%) (*p.* 017).

2.4.3 Critique of instruments used to measure DFV

Different tools to measure aspects of DFV in different settings and for different purposes have proliferated during the last two decades (Thompson, Basile, Hertz, & Sitterle, 2006). Seeking to capture a multitude of abusive behaviours, DFV measures can be distinguished by their length and language (Thompson et al., 2006). Some tools are developed as short instruments to screen for the presence of DFV in a clinical setting, while others are designed to comprehensively assess DFV frequency, behaviours and risk, often for the purposes of research (Gomez-Fernandez et al., 2019; Hegarty et al., 2005; McFarlane et al., 1992). In general, 12-month measures of IPV are inherently more reliable than lifetime measures because human memory is more reliable the shorter the recall timeframe (Visschers, Jaspaert, & Vervaeke, 2017). Screening tools are typically 10-items or less, while research measures are often lengthier inventories of specific behavioural acts and are considered to have greater reliability (Gomez-Fernandez et al., 2019). Questions that are not behavioural rely on a respondent to apply their own understanding or conceptualisation of an issue (Leung et al., 2019). For example, a non-behavioural question that asks: *Have you experienced domestic violence?* (Doyle et al., 1999) will lead to different interpretations by respondents as they utilise their range of experience to determine what consititutes ‘domestic violence’ for them. Behavioural measures by contrast, ask direct questions about abusive behaviours, for example, “*Has a current or former partner insulted you or made* *you feel bad about yourself?*" (García-Moreno et al., 2005; Khan et al., 2014). Behavioural measures reduce the range of interpretation since respondents are asked about the presence of specific behaviours during a set period, usually in the recent past (Leung et al., 2019). It is common for measures to be validated with a specific population who may not be representative of the broader community (e.g. women accessing DFV emergency services) (Gomez-Fernandez et al., 2019; Thompson et al., 2006). Therefore, a critique of most tools is their ethnocentricity and heteronormativity; rarely are tools developed or tested with people who identify as belonging to diverse racial or ethnic groups or sexual orientations (Thompson et al., 2006).

A variety of research and screening measures were employed across the fifteen studies included this literature review (Table 5), ranging in number of abuse items from one (Early & Williams, 2002) to 30 (deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001). The measure used most commonly was the World Health Organization Multi-Country Study on Women's Health and Domestic Violence (WHO MCS) (García-Moreno et al., 2005) (Christofides & Silo, 2005; Khan et al., 2014; Mitchell et al., 2013; Sharma & Vatsa, 2011). Nine studies utilised either the WHO MCS or another validated behavioural measure (Al-Natour et al., 2014; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; Diaz-Olavarrieta et al., 2001; Khan et al., 2014; Mitchell et al., 2013; Sharma & Vatsa, 2011; Stenson & Heimer, 2008), although one measure had not been validated at the time of the study (deLahunta & Tulsky, 1996). The remaining six included studies created a bespoke measure that was not validated at either the time of the research, or later (Bracken et al., 2010; Candib et al., 2012; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Rodriguez et al., 1999). All but three studies examined lifetime IPV or DFV, without reporting current or 12-month abuse, raising recall issues (Al-Natour et al., 2014; Candib et al., 2012; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Khan et al., 2014; Mitchell et al., 2013; Rodriguez et al., 1999; Smith, 1987; Stenson & Heimer, 2008).

The prevalence derived from the application of a DFV tool is central to a study's findings. For this reason, the validated tools used across the studies identified in the literature search will now be briefly reviewed - divided by their purpose for clinical screening or research. It is not intended that this be an exhaustive review of all available DFV measures, but a critique of the four different validated tools utilised in the 15 studies: WHO MCS (García-

Moreno et al., 2005), NorVold Abuse Questionnaire (Swahnberg & Wijma, 2003), Woman Abuse Screening Tool (WAST) (Brown et al., 1996) and Abuse Assessment Screen (AAS) (McFarlane et al., 1992). Additionally, the most commonly used DFV research measure, the Conflict Tactics Scale 2 (CTS2) (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), will be appraised here to establish context in this field. One of the included studies set in the UK asked four questions from the ‘Intimate Personal Violence and Partner Abuse self-completion module’ of the *Crime Survey for England and Wales 2012/13* (Cavell Nurses' Trust, 2016). Information about this population measure, including its validity and reliability, is not freely available, which prevented it from inclusion in this review. Half (seven) of the included studies used a bespoke DFV measure and, similarly, will not be reviewed here (Bracken et al., 2010; Candib et al., 2012; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Mitchell et al., 2013; Rodriguez et al., 1999).

Table 5. Scales used to measure violence in included studies

Name	Tool purpose	DFV type	Year	No. of items	No. of respondents (% response rate)	Sampling	Factors (Reliability) [1]	Validity
WHO MCS (García-Moreno et al., 2006; Heise, Pallitto, Garcia-Moreno, & Clark, 2019)	Research	Adult IPV (12-month, adult lifetime): Physical Sexual Control	2005	16	24,097 women (60.2 - 99.7%)	Random	12-month Physical/Sexual (.84) Lifetime Control (.68)	Convergent Criterion
		Psychological	2019	4	19,526 ever-partnered women [2]		Lifetime Psychological (.78)	
NorVold Abuse Questionnaire (Swahnberg & Wijma, 2003)	Research & clinical screen	Lifetime abuse (including in the health care system): Physical Sexual Emotional	2003	13	590 women (61%)	Random	Emotional (.57) [3] Physical (.86) Sexual (.77) Health care system (.54)	Concurrent
WAST (Brown et al., 1996; Brown, Lent, Schmidt, & Sas, 2000)	Clinical screen	Adult IPV (12-months) Emotional Physical Psychological Sexual	1996 (Pilot)	8	24 survivor women / 24 professional contacts of the author (unpublished %)	Convenience	Emotional/ Physical/ Psychological/ Sexual (.95)	Content Construct Discriminant
			2000 (Validation)	8	307 attending general practice (67.3%)		Emotional/ Physical/ Psychological/ Sexual (.75)	Content Construct [4]
CTS2 (Straus et al., 1996)	Research	Adult IPV (12-month, adult lifetime): Physical Sexual Psychological	1996 (CTS 2) 1979 (CTS 1)	39	317 undergraduate students (97.2%)	Convenience	Negotiation (.86) Psychological aggression (.79) Physical assault (.86) Sexual coercion (.87) Injury (.95)	Construct Discriminant

AAS (McFarlane et al., 1992)	Clinical screen	Adult IPV during pregnancy (12-month): Physical Sexual	1992	3	691 pregnant women (unpublished %)	Stratified	Physical/Sexual (.80)	Construct

Notes

[1] Measured using Cronbach's alpha

[2] Response rates exceeded 85% in all regions except Japan

[3] Measured using kappa measure of agreement for 'moderate' severity

[4] Limited construct validity demonstrated (r=0.69, *p*=.01)

WHO Multi-Country Questionnaire

The WHO MCS is a 16-item measure of the frequency of physically and sexually abusive and controlling behaviours and was used in more of the studies identified by the search than any other (García-Moreno et al., 2005). Specifically, Khan et al. (2014); Mitchell et al. (2013), Sharma and Vatsa (2011) and Christofides and Silo (2005) employed full or abridged versions. The WHO MCS has been translated and tested in 10 developing and industrialised countries to be delivered face-to-face by trained interviewers (García-Moreno et al., 2006). Until recently, a major drawback of this measure was that the authors had yet to publish prevalence estimates of emotional violence because of concerns about a lack of cross-cultural consensus about its definition (García-Moreno et al., 2006; Heise et al., 2019). Psychological abuse has now been measured using a gradient (three level) categorisation, rather than a threshold, and has retrospectively been found to be highly prevalent in all countries captured by the original multicounty study (Heise et al., 2019). However, emotional abuse remains undefined and yet to be measured, rendering common aspects of IPV described as harmful by survivors absent from the WHO MCS (Heise et al., 2019).

NorVold Abuse Questionnaire

The first prevalence instrument to be validated across five Nordic countries, the NorVold Abuse Questionnaire (Swahnberg & Wijma, 2003) is a 13-item measure of lifetime physical, sexual and emotional abuse (i.e. as a child or adult) and was used by Stenson and Heimer (2008) in their DFV study of nurses, doctors and allied health professionals. Developed as a research tool, its employment can also be for the purposes of screening (Swahnberg, 2011). Distinctly, this measure captures abuse in healthcare, as well as abuse by different perpetrators across the life course (Swahnberg, 2011; Swahnberg & Wijma, 2003). A problem with the NorVold is that it does not include abuse frequency, or report on type of perpetrator relationship (i.e. intimate partner). Furthermore, the NorVold demands long recall, asking about abuse as a child, adult, or both and it has specifically been validated for use in Nordic countries (Simmons, Wijma, & Swahnberg, 2015; Swahnberg & Wijma, 2003).

Short screening tools: WAST & AAS

Both the WAST and the AAS were developed as brief DFV 12-month screening tools for use with women in healthcare settings (Brown et al., 1996; McFarlane et al., 1992). Al-

Natour et al. (2014) used the 8-item WAST in their study, while deLahunta and Tulsky (1996), as well as Janssen et al. (1998), used abridged versions of the AAS (Brown et al., 1996; McFarlane et al., 1992). Developed in the UK and Canada, the 8-item WAST screens for the presence of psychologically, sexually and emotionally abusive behaviours, whereas from the USA, the AAS is pregnancy-specific, with three questions to gauge physical and sexual abuse in the last 12-months (Brown et al., 1996; McFarlane et al., 1992; Soeken, McFarlane, Parker, & Lominack, 1998). While screening tools are brief and therefore less onerous for women to complete, a major problem affecting them is their capability to detect probable cases; they can misidentify survivor women by comparison with more comprehensive measures (Gomez-Fernandez et al., 2019; Wathen, Jamieson, MacMillan, & The McMaster Violence Against Women Research Group 2008). For example, in a randomised control trial assessing IPV screening by comparing the WAST and the Composite Abuse Scale (CAS), the WAST was shown to over-identify woman as abused (22% compared to 14%) (Hegarty et al., 2005; Wathen et al., 2008).

CTS2

While not a measure used in any of the included 15 studies, the original Conflict Tactics Scale (CTS), and its second iteration, the CTS2, is the most widely used assessment of IPV, measuring self and partner-perpetrated abusive behaviours over the past 12-months and ever (Babcock, Snead, Bennett, & Armenti, 2019; Straus et al., 1996). The purpose of including the CTS2 in this summary of the measures used across the 15 studies is to provide context given the popularity of this tool (Babcock et al., 2019). The underlying premise of the CTS2 is that there are various ways of dealing with conflict in a family; the measure is designed to be completed by both members of a couple. Frequency counts then distinguish violence as either unilateral or bilateral (Babcock et al., 2019). The most significant criticism of the revised 39-item tool (CTS2) is its failure to assess the context and purpose of violent behaviours (Babcock et al., 2019; Hegarty et al., 2005). This misconstrues perpetrators of violence as being gender-blind, silencing differences in the dynamics of power, fear and intimidation between members of a heterosexual couple (Babcock et al., 2019; Hegarty et al., 2005). In response to these concerns, CTS2's author, Straus et al. (1996), argued that self-defence was not the predominant explanation for either women's or men's violence. However, a meta-analysis found that to be false; self-defence is a primary motivation for women's use of violence and bilateral application of the CTS2 can therefore mask context, danger and impact of abusive behaviours (Bair-Merritt et al., 2010). The CTS2 was recently described as “overly simplistic and fails to capture different types of bilateral aggression” (Babcock et al., 2019, p. 687). Other criticisms of the CTS2 include the measurement of conflict rather than coercive tactics and the absence of emotional abuse items (Babcock et al., 2019; Hegarty et al., 2005; Hegarty & Roberts, 1998; Wathen et al., 2008).

This concludes the narrative analysis of DFV measures. From here, further aspects of the 15 included studies will be synthesised by their gendered prevalence and how the findings sit within a population context.

2.4.4 Gendered prevalence of violence

All fifteen studies sampled female healthcare professionals, with six also surveying males (Candib et al., 2012; Cavell Nurses' Trust, 2016; deLahunta & Tulsky, 1996; Early & Williams, 2002; Mitchell et al., 2013; Rodriguez et al., 1999). Across the five studies that separated the sexes in their analysis, unsurprisingly, a gendered difference emerged in exposure to DFV. For lifetime exposure to DFV, the average prevalence for female participants was between two and five times higher than it was for males (Candib et al., 2012; deLahunta & Tulsky, 1996; Mitchell et al., 2013; Rodriguez et al., 1999). The only study that did a comparison of male and female survivors in the last 12-months found that women were 2.3 times more likely to have experienced fearful or threatening violence from their partner during that time (Cavell Nurses' Trust, 2016).

2.4.5 Prevalence in the context of the population

Where prevalence in the context of the population was stated or could be inferred, commonly the prevalence of IPV and DFV against health professional participants was consistent with the corresponding population prevalence in the area where the research occurred (Al-Natour et al., 2014; Bracken et al., 2010; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). However, population equivalence was not the case for seven of the included studies. Four studies found health professionals had a higher DFV prevalence compared to the general community (Cavell Nurses' Trust, 2016; Janssen et al., 1998; Khan et al., 2014; Mitchell et al., 2013). Of these, three identified an adult lifetime IPV prevalence rate approximately 10 percent higher for health professionals than the rest of the community (Janssen et al., 1998; Khan et al., 2014; Mitchell et al., 2013);

while the fourth, Cavell Nurses' Trust (2016), found the 12-month prevalence of physical and non-physical IPV was two to four times higher among the 2,254 nurses and healthcare assistants in their study compared to the general UK population, using the same measure. The remaining three included studies found participating health professionals had experienced less violence in their lives compared to their population peers, albeit using different measures (Candib et al., 2012; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999).

Summary of the health professional DFV & prevalence literature

A search of the academic literature found 15 studies about DFV against health professionals across the lifetime. These studies employed a range of instruments to measure DFV, some of which were bespoke, and of those that were validated, the WHO MCS was most common (García-Moreno et al., 2005). Most of the studies investigated nurse participants (Al-Natour et al., 2014; Bracken et al., 2010; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; Diaz-Olavarrieta et al., 2001; Early & Williams, 2002; Janssen et al., 1998; Mitchell et al., 2013; Sharma & Vatsa, 2011), and there was no difference in the prevalence of DFV based on health professional background. There were, however, gendered prevalence differences detected (Candib et al., 2012; deLahunta & Tulsky, 1996; Mitchell et al., 2013; Rodriguez et al., 1999) and the prevalence of DFV against health professional participants was most often the same as the broader population in which the research took place (Al-Natour et al., 2014; Bracken et al., 2010; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). This review of the academic literature now moves to studies that addressed the question of whether DFV exposure was associated with health professional clinical readiness to respond to survivor patients.

2.5 SURVIVOR HEALTH PROFESSIONAL READINESS TO RESPOND

In exploring how health professionals’ personal exposure to DFV influences their clinical care of survivor women, mixed, and at times, contradictory evidence characterised the literature. Despite secondary survivors being excluded from formal inclusion in the selected 15 studies, a summary of the few studies that defined their DFV exposure group as secondary survivor health professionals may be helpful to answering the research questions of this thesis. Similarly, the qualitative literature about the impact of DFV exposure on health professionals will be explored. This is followed by a rigorous evaluation of the quantitative evidence about associations between health professional primary exposure to DFV and readiness to respond to survivor patients. After consideration of this research, this Chapter will move to establishing the gap in what is known, providing a narrative review of the employment support literature.

2.5.1 Qualitative studies about health professional DFV & clinical care

Four qualitative studies have explored whether personal DFV exposure can act as a barrier or facilitator to health professionals' readiness to respond to patient DFV (Beynon et al., 2012; Mezey et al., 2003; Moore, Zaccaro, & Parsons, 1998; Sugg & Inui, 1992). Beynon et al. (2012) analysed qualitative data from a larger study of 931 nurses and doctors about routine DFV enquiry with patients (Beynon et al., 2012; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). Open-ended questions were answered by 769 participants, whose responses were thematically analysed and the top five barriers and facilitators investigated (Beynon et al., 2012). Health professional personal experience of DFV did not emerge as a barrier, but it was identified as the fifth most common enabler of good practice, with some nurses and doctors saying it enhanced their capacity to work with survivor women. As one nurse in the study said, "my personal experience with abuse provides me with a comfort level, knowledge of the system and a desire to support and empower women" (Beynon et al., 2012, p. 8). Mezey et al. (2003) did qualitative interviews with 28 midwives about perceptions and experience of DFV routine enquiry. Some clinicians named their personal DFV exposure as a barrier, because it activated feelings of distress (Mezey et al., 2003). Others, however, attributed their personal experience of DFV to making them more sensitive to signs of DFV among their patients, more committed to DFV clinical care and more aware of issues for survivors (Mezey et al., 2003). Analysing the open-ended comments of a larger descriptive survey with 275 nurses, Moore et al. (1998) found the most common response to a question about the effect of DFV personal exposure on clinical care was, "exposure leads me to try to identify victims of abuse" (Moore et al., 1998, p. 179). Sugg and Inui (1992) authored the earliest study about DFV against health professionals, interviewing 38 doctors about DFV identification and response to women in primary care. This study found no difference between the descriptions of clinical care offered by the survivor doctors compared to their non-abused peers (Sugg & Inui, 1992).

In summary, across the four qualitative studies that have explored the impact of health professional personal DFV exposure on DFV clinical care readiness, the findings were mixed.

However, three studies did find health professional DFV exposure to be an enabler of readiness for some survivor clinicians (Beynon et al., 2012; Mezey et al., 2003; Moore et al., 1998), while one study found it could also pose a barrier (Mezey et al., 2003), and in the other, exposure was a factor of no influence (Sugg & Inui, 1992).

2.5.2 Secondary DFV exposure & clinical care of survivor patients

The literature review uncovered four quantitative studies that asked the question: is DFV exposure associated with readiness to address DFV? (Dickson & Tutty, 1996; Early & Williams, 2002; Gutmanis et al., 2007; Moore et al., 1998). However, these four studies did not separate primary survivor health professionals from those with secondary exposure in their analysis (Dickson & Tutty, 1996; Early & Williams, 2002; Gutmanis et al., 2007; Moore et al., 1998). This was a significant methodological flaw rendering them outside the scope of the included studies about health professional exposure and clinical care since all health professionals can be assumed to have had secondary DFV exposure if the definition is knowing someone (e.g. a friend, family member or patient) who has been affected by the issue. Table 6 summarises the findings of these four studies. Two of the four studies observed an association between secondary DFV exposure and improved readiness to respond, although for one, the association only occurred in combination with DFV training (Dickson & Tutty, 1996; Gutmanis et al., 2007). These studies reinforce the ambiguity about whether health professional DFV exposure influences clinical care of survivor women.

Table 6. Aspects of clinical care associated with secondary DFV exposure

Clinical care dimension	Association with clinical care	Researchers	Type of study
General DFV clinical care	No association	Early and Williams (2002)	- Survey using vignettes; - Non-survivor HP[1] n=117 / survivor HP n=78 - Analysis did not adjust for confounders
	Exposure was associated with HPs' self-reporting better care for survivor patients	Dickson and Tutty (1996)	- Survey using vignettes; - Non-survivor HP n=104 / survivor HP n=19 - Analysis did not adjust for confounders
Preparedness to address DFV	HPs with both personal exposure and history of DFV training were significantly more prepared to respond (increase of 0.11, t-test: 2.278, p<.01) Personal exposure alone not associated with preparedness	Gutmanis et al. (2007)	- Modified Dillman Tailored Design - Non-survivor HP n=463 / survivor HP n=451 - Analysis adjusted for confounders - Personal exposure to DFV and training separated in findings
DFV attitudes	No association found	Gutmanis et al. (2007)	As above
	No association found	Moore et al. (1998) [2]	- Descriptive study of responses to a survey - n=275 (between 22-37% survivors) - Analysis did not adjust for confounders

Notes

[1] HP: Health professional

[2] Qualitive finding of this study found personal exposure to be an enabler of DFV patient routine enquiry

2.5.3 Primary DFV exposure & clinical care of survivor patients

Four of the fifteen studies uncovered via Search Strategy One went further than reporting health professional DFV prevalence by also investigating clinical impacts associated with primary exposure (Candib et al., 2012; Christofides & Silo, 2005; Rodriguez et al., 1999; Stenson & Heimer, 2008). The four studies appraised aspects of DFV patient clinical care including screening (Candib et al., 2012; Rodriguez et al., 1999; Stenson & Heimer, 2008), identification of survivors (Christofides & Silo, 2005; Stenson & Heimer, 2008), perceived barriers to clinical practice (Candib et al., 2012) and quality of patient care (Christofides & Silo, 2005). Table 7 presents further information to that contained in Table 4.

Table 7. Aspects of clinical care associated with primary DFV exposure

Clinical care dimension	Study [1]	Exposure	Clinical care findings	Strengths & limitations of analysis
Screening Barriers to DFV care	Candib et al. (2012) USA	Primary and secondary exposure to IPV & DFV	- Primary exposure to DFV associated with feeling moderately to very confident to screen patients for childhood trauma (61.6% vs 44.9%, *p*=.007), however rate of screening did not reach significance (*p*=.055) - Secondary exposure (outside professional role) associated with primary exposure (childhood DFV) (88.8% vs 67.3%, *p*=.001) - Personal exposure associated with being less likely to identify time as a barrier to patient screening (mean score 1.73 vs 1.57, *p*=.018)	- Analysis did not adjust for confounding variables - Male & female data not separated in analysis
Screening Identification Interventions	Stenson and Heimer (2008) Sweden	Primary and secondary exposure to DFV	- Primary DFV exposure not associated with screening; practice, identification of survivor patients or interventions with survivor patients - Secondary DFV exposure (family/acquaintance) associated with identifying survivor patients more frequently (Adj. OR 2.3, 95% CI 0.5, 2.3, *p*.020) - Training positively associated with screening, identification and interventions with survivor patients (Adj. OR 3.3, 95% CI 2.2, 4.8, *p*.000)	- Analysis adjusted for years of experience, >/< 0 hrs of IPV training, employment status, professional background
DFV knowledge Attitudes Interventions	Christofides and Silo (2005) South Africa	Primary and secondary exposure to IPV	- IPV training not associated with identification of survivor patients - No association between primary IPV exposure and survivor quality of care - Association between secondary IPV exposure (family/friends) and identification of survivor patients & clinical management (Wald Chi^2 = 7.22, *p* = 0.02)	- Analysis did not adjust for confounding variables
Screening Association between recent training & patient screening	Rodríguez et al. (1999) USA	Primary IPV exposure	- IPV exposure not associated with screening - Recent IPV training not associated with IPV patient screening	- Adjusted for sex, clinical setting & training in analysis

Notes

[1] All studies introduced in Table 4 (page 33)

As Table 7 demonstrates, no study found primary DFV exposure to be associated with any aspect of survivor clinical care, including screening, identification nor quality of care, although one study found exposure to be associated with feeling more confident to screen and being less likely to identify time as a barrier (Candib et al., 2012). Three of the four studies investigated primary and secondary survivors and while primary exposure to DFV was not associated with clinical care, secondary exposure through family or friends appeared to be associated with a greater likelihood of identifying survivor women (Christofides & Silo, 2005; Stenson & Heimer, 2008), as well as enhanced clinical care (Stenson & Heimer, 2008). This distinction between the findings specific to primary and secondary survivor health professionals reinforces the caution with which studies that do not separate exposure groups should be regarded. The dimension of care most studied was patient screening, reported by three of four papers (Candib et al., 2012; Rodriguez et al., 1999; Stenson & Heimer, 2008). The same number of studies were interested in the relationship between professional DFV training and clinical care (Christofides & Silo, 2005; Rodriguez et al., 1999; Stenson & Heimer, 2008); with one finding training was positively associated with screening, identification and interventions with survivor patients (Stenson & Heimer, 2008).

Of the four studies, the most methodologically sound surveyed Swedish female health professionals about knowledge and practice with survivor women (Stenson & Heimer, 2008). Of the 588 health professional participants, 23.5% had experienced abuse by a partner, while a further 22.1% were family members of, or acquainted with a DFV survivor (Stenson & Heimer, 2008). After adjusting for professional background, experience and training via logistic regression, Stenson and Heimer (2008) found that care of survivor patients was not associated with primary exposure to DFV, however having had secondary exposure to DFV was: those with survivor friends or family were more likely than others to identify survivors and recontact them once or more per month.

2.5.4 Study limitations

Across the fifteen included studies, substantial limitations concerned measures used, recall timeframes, sample size, response rate, age, sampling and context. These largely methodological problems inhibited the studies’ capacity to answer research questions about the prevalence of DFV against health professionals and whether exposure is associated with clinical care of survivor patients. Differences in DFV prevalence were identified across the health professionals studies and some of that variability is almost certainly explained by the measures used. If a measure comprises few items, does not ask about specific abusive behaviours or has not gone through a validation process, limited learnings may be able to be derived from the results (Bracken et al., 2010; Candib et al., 2012; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Early & Williams, 2002; Mitchell et al., 2013; Rodriguez et al., 1999). Related to the overall rigour of a DFV measure is its recall period, and lengthy time frames affected most of the studies (Al-Natour et al., 2014; Candib et al., 2012; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Khan et al., 2014; Mitchell et al., 2013; Rodriguez et al., 1999; Stenson & Heimer, 2008). Finally, the number of participants and the response rate indicates the strength, representativeness and generalisability of a study. To reveal some of the issues that can affect a study's prevalence findings, two examples (12-month and lifetime) are compared and presented in Boxes 1 and 2 below. These examples demonstrate that a plethora of methodological issues can directly affect a study's findings and should frame their interpretation.

Box 1. A profile of three 12-month prevalence studies using different measures

Of the 15 included studies, only three investigated the 12-month prevalence of DFV, and nurses were the participants in all (Bracken, Messing, Campbell, La Flair, & Kub, 2010; Cavell Nurses' Trust, 2016; Sharma & Vatsa, 2011). Given the 12-month recall period, these three studies were likely less affected by the memory limitations of their participants compared to studies in which lifetime DFV questions were asked (Smith, 1987). Nevertheless, there were other issues that may have affected the reliability of the study's findings. Cavell Nurses' Trust (2016) measured IPV against nurses in the UK, the study by Bracken et al. (2010) took place in the USA, and Sharma and Vatsa (2011) conducted a study in India. Each project employed a different instrument to measure prevalence, ranging in number of items from four (Cavell Nurses' Trust, 2016) to seven (Bracken et al., 2010), with one choosing not to report (Sharma & Vatsa, 2011). Two studies used a validated measure (Cavell Nurses' Trust, 2016; Sharma & Vatsa, 2011), the other created their own (Bracken et al., 2010).

Bracken et al. (2010) reported 1.5% prevalence of physical IPV during the previous 12-months, Sharma and Vatsa (2011) identified 35% prevalence, while for the nurses in the Cavell Nurses' Trust (2016) study, it was 3.1%. Some of the variability between the three studies' physical IPV prevalence rates is likely explained by the context in which the research occurred. For example, Sharma and Vatsa (2011) reported a substantially higher prevalence than the other two studies, consistent with the broader population prevalence. This may reflect issues of gender equity and indicate the substantial disparity Indian women face (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). However, it is worth keeping in mind that the authors of this study only recruited 60 nurses and encountered a low response rate (5.2%) (Sharma & Vatsa, 2011). The prevalence findings by Bracken et al. (2010) were also consistent with the population from which they emerged, despite using a different (bespoke) measure. Their study surveyed 1,981 participants and reported the highest response rate of the three studies at 52% (Bracken et al., 2010). Cavell Nurses' Trust (2016) surveyed the largest number of participants, 2,254, and found that IPV was higher against nurses than in the general population. Further, this study departed from the others by using the same measure as the population survey, which might suggest more reliable findings. However, less than one percent of those to whom the survey was sent, completed it, the lowest response rate of the three studies. It is possible that those who did not respond to the survey differed in a meaningful way to those who did, demanding interpretive caution (McNutt & Lee, 2000).

Box 2. A profile of two studies of lifetime IPV against doctors in the USA

To explore some of the issues affecting a study's findings among the research about lifetime DFV, two of the included studies with similar participants, setting and location will now be compared. Candib, Savageau, Weinreb, and Reed (2012) and Doyle, Frank, Saltzman, McMahon, and Fielding (1999) investigated the lifetime prevalence of intimate partner violence against doctors in family practice in the USA. The study by Doyle et al. (1999) came first, with Candib et al. (2012) 13 years later. Both studies designed their own IPV questions which were not validated. However, only one of the measures was behavioural, comprising five items (Candib et al., 2012), while the other asked two IPV questions, including if a respondent had experienced "domestic violence" (Doyle et al., 1999), a method associated with missing cases of IPV (Gomez-Fernandez, Goberna-Tricas, & Paya-Sanchez, 2019). Both studies reported a lower lifetime prevalence compared to the general population, although the IPV prevalence rate of 15.7% against doctors in the study by Candib et al. (2012), was double that of Doyle et al. (1999) (7.4%). The use of a behavioural prevalence measure by Candib et al. (2012), comprising a greater number of items, could establish it as the stronger of the two studies (Candib et al., 2012; Doyle et al., 1999). However, Doyle et al. (1999) reported a higher response rate (59% compared to 45.5%) and recruited more than 11 times the number of participants (4501 compared to 380 in Candib et al., 2012). On balance, it could be argued that, in this example, Candib et al. (2012) is the more rigorous of the two studies given the use of a more accurate prevalence measure, and a response rate, that, while lower than Doyle et al. (1999), is nonetheless acceptable (Edwards et al., 2002).

Several specific limitations were identified across the fifteen international studies about the prevalence of DFV against health professionals. For a start, half of the studies used a prevalence measure that had not been validated at the time of its use (Bracken et al., 2010; Candib et al., 2012; deLahunta & Tulsky, 1996; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Rodriguez et al., 1999). Having not undergone a rigorous assessment of psychometric characteristics including reliability, specificity, sensitivity or validity, measures should be interpreted with caution (Gomez-Fernandez et al., 2019; Thompson et al., 2006). Second, three of the included studies relied on non-behavioural questions about DFV (Bracken et al., 2010; Doyle et al., 1999; Janssen et al., 1998). This was problematic because of the prerequisite that participants apply their subjective interpretation of what consititutes DFV (Leung et al., 2019). Third, in five of the included studies, the number of DFV questions employed to establish prevalence was less than three (Doyle et al., 1999; Early & Williams, 2002; Rodriguez et al., 1999) or was not published (Christofides & Silo, 2005; Sharma & Vatsa, 2011). Depending on few items to establish a prevalence rate runs the risk of misidentifying survivors (Gomez-Fernandez et al., 2019; Wathen et al., 2008). Fourth, one study chose face-to-face delivery, a method that is associated with decreased odds of disclosure (Christofides & Silo, 2005; Hussain et al., 2015). Fifth, five studies diverged from a convenience sample design by employing random sampling; increasing their study's rigour by reducing the potential for self-selection bias (Al-Natour et al., 2014; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Rodriguez et al., 1999; Stenson & Heimer, 2008). Sixth, a minority of the studies had a response rate of less than ten percent (Sharma & Vatsa, 2011) or chose not to publish a response rate (Cavell Nurses' Trust, 2016; Early & Williams, 2002). This reduces the generalisability of those studies because of the risk that those who did participant might have differed in a meaningful way from those who did not (McNutt & Lee, 2000). Seventh, studies with sample sizes of between 60-200 respondents were smaller than three quarters of the other studies in this field, limiting the strength of their evidence (Al-Natour et al., 2014; Janssen et al., 1998; Sharma & Vatsa, 2011). Eighth, many of studies were published more than ten years ago and may require an update (Bracken et al., 2010; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Janssen et al., 1998; Rodriguez et al., 1999). Finally, some studies were conducted in countries whose population prevalence rate was substantially higher than that reported in the Australian community (Diaz-Olavarrieta et al., 2001; Khan et al., 2014; Mitchell et al., 2013; Sharma & Vatsa, 2011). This is not a limitation of course, but it hinders the generalisability of those studies within the Australian context.

This search of the academic literature established that the field of study about associations between health professional exposure to DFV and clinical care of survivors was limited to four. Of those, serious methodological issues warranting interpretive caution affected three (Candib et al., 2012; Christofides & Silo, 2005; Rodriguez et al., 1999). Two did not adjust for potentially confounding factors in their analysis, and many variables including professional DFV training and age may have distorted their results (Candib et al., 2012; Christofides & Silo, 2005). Furthermore, one of these studies did not separate male and female data in their analysis (Candib et al., 2012), obscuring the learnings able to be obtained since it is well-established that the experience of DFV is gendered (Cox, 2015; Krug et al., 2002). The third study, now 20 years old, defined their survivor exposure group based on a two-question non-validated DFV screen (Rodriguez et al., 1999). A comprehensive definition of violence comprising different types of abuse, frequency and context is recommended (Alexander, 1993; Hegarty et al., 2005).

Summary of the survivor health professional literature

In considering all of the evidence, this literature review has revealed that the 12-month and lifetime prevalence of DFV against Australian health professional women is not known. Collectively, the 15 included studies suggested that the prevalence of DFV against health professionals may be the same as the general population, and since health professionals are front line responders to women who have experienced violence in the community, the question arises: what impact if any, does personal exposure to DFV have on health professionals' readiness to respond to survivor women? However, the literature available to shed light on that issue was sparse and affected by methodological issues inhibiting applicability and generalisability. The need for a more rigorous study into the prevalence of DFV against health professional women, and associations with clinical care, is concluded.

The purpose of answering research questions about how common DFV trauma is in health professional women's lives and the impact it has on their clinical work is to better understand and support health professionals. There is an important system with which health professionals interact daily, and that is their workplace. Nurses, doctors and other health professionals are employed by health services to care for patients, while the organisation is accountable for providing a safe and supportive environment for staff (Rayner-Thomas et al., 2014). The evidence reviewed in this Chapter so far suggests another pertinent topic for exploration: the role of the healthcare workplace in responding to survivor staff. Departing from the 15 included studies reviewed above about the prevalence and impact of DFV against health professionals, this Chapter now turns to a second search of the literature, this time reviewing the evidence about hospitals as the workplace of health professional staff. Hospitals would seem an employment setting worthy of particular attention regarding their response to survivor staff because it is there that a confluence of factors co-occur: DFV survivors are employed, health professionals' have clinical responsibility to identify and respond to survivor women, and hospitals deal with higher rates of occupational violence (i.e. from aggressive patients) than affect other employment settings (Perrone, 1999; Shea et al., 2017). In synthesising the workplace response to survivor staff research, this next section of this literature review will provide further context to the present study.

2.6 THE EMPLOYMENT RESPONSE TO DFV

2.6.1 Survivor perceptions about the workplace

Employers may have little to no awareness that DFV is an issue affecting their employees since it is common for survivors to remain silent about their abuse experiences, including, and perhaps especially, at work (Commonwealth of Australia, 2009; Swanberg, Macke, & Logan, 2006; Tolman & Wang, 2005). Research about the role of the workplace in relation to DFV has suggested that employee survivors make decisions not to share their survivor experience at work for a range of reasons, including fear of negative repercussions, the belief that DFV is a private matter, and concern for personal safety if the perpetrator were to become aware (Swanberg et al., 2006). Some women do raise DFV at work and find this helpful, particularly having a ‘listening ear’, paid time off, assistance with safety planning and referral (Swanberg & Logan, 2005; MacGregor, Wathen, Olszowy, Saxton, & MacQuarrie, 2016). However, a USA study of 500 employees in private business by Kulkarni and Ross (2016) found that survivor employees who had disclosed DFV at work perceived their workplace as less supportive and accommodating regarding DFV than their peers. This means that those who had not experienced DFV or had not attempted to access support for the issue, held a philosophical belief that the workplace was more supportive and accommodating than was the self-reported experience of survivors who had actually utilised the system (Kulkarni & Ross, 2016).

Three studies have now used the same measure by McFerran (2011) to investigate the impact of DFV on the workplace, including workplace support (MacGregor, Wathen, Olszowy, et al.; McFerran, 2011; Rayner-Thomas et al., 2016). These studies with women employed across different sectors in Australia (McFerran, 2011), New Zealand (Rayner-Thomas et al., 2016) and Canada (MacGregor, Wathen, Olszowy, et al., 2016) have, combined, included more than 4,000 survivor participants. While close to half of the survivors in these studies had disclosed DFV to someone at work, the majority who had chosen not to cited shame, embarrassment, privacy and fear of negative repercussions, as the reasons (MacGregor, Wathen, Olszowy, et al., 2016; McFerran, 2011; Rayner-Thomas et al., 2016). The common workplace supports offered in response to a disclosure of DFV in these studies were paid or unpaid leave, a listening ear, safety planning and referral (MacGregor, Wathen, Olszowy, et al., 2016; Rayner-Thomas et al., 2016). Across these studies, most survivors had not received a negative response to raising DFV, although for the majority in the McFerran (2011) study, and up to a third in the study by Rayner-Thomas et al. (2016), nothing had changed as a result of their disclosure.

2.6.2 Managers & the workplace

Research suggests that there may be a mismatch between the support DFV survivor employees want and need from their workplace, and that which they actually receive (Glass, Hanson, Laharnar, Anger, & Perrin, 2016; Laharnar et al., 2015; Swanberg et al., 2005; Swanberg, Macke, & Logan, 2007; Yragui et al., 2012). This concept of a support "match" between survivors and their managers emerged from a study which found that whether a manager's support matched the survivor employee's needs, or there was a mismatch, was predictive of a majority of work outcomes, including job satisfaction, workplace reprimands and termination (Yragui et al., 2012). Of the available workplace support research, most of it has been about the perceived helpfulness of outcomes offered to an employee after disclosure (Glass et al., 2016; Kulkarni & Ross, 2016; Laharnar et al., 2015; MacGregor, Wathen, Olszowy, et al., 2016; Samuel, Tudor, Weinstein, Moss, & Glass, 2011; Yragui et al., 2012). This contrasts with asking survivor employees to pre-emptively characterise the components of a supportive workplace response.

2.6.3 Hospital responses to survivor staff

While there is some research about general workplace responses to survivor staff, a question arises about the specific needs and experiences of people employed by a hospital? What do health professionals, managers and other key stakeholders say their healthcare organisation needs to provide for staff who have experienced DFV? In an extensive narrative review of the international literature about DFV support when the setting is a healthcare workplace (see search strategy in Appendix A), only one study could be located that included health professionals among the participants (*N*=3,611, response rate

~4.6%) (McFerran, 2011). This suggests that hospitals, as a type of workplace, have not been investigated in terms of the support needs and experiences of their survivor staff. A study by McFerran (2011) investigated the experience of teaching, nursing and public sector trade union members (neither participants' professional backgrounds, nor their gender, were separated in the findings). This study examined the impacts and outcomes of discussing DFV at work for the 30% who had experienced lifetime DFV (5% in the last 12-months) (McFerran, 2011). Nearly half of the participants reported that DFV sometimes affected their capacity to get to work, with 15% affected by DFV while at work (McFerran, 2011). Half (48%) had disclosed DFV to their supervisor, although only 10% found that helpful. As a result of discussing DFV with someone at work, most survivors found that either nothing changed or the outcome was negative, with paid leave the main form of assistance offered (19%) (McFerran, 2011). This study had a few limitations: the response rate was low, it did not use a validated or behavioural measure of DFV and contained only one DFV item (McFerran, 2011). Nevertheless, the study indicates that, for these workers, there was more they needed from their workplace to feel supported.

In addition to the scant literature about the needs and experiences of DFV survivor health professionals, a search was unable to locate any studies about hospital managers' views on the role of the workplace in responding to survivor employees. This is despite several studies outside healthcare having identified the positive impact management can have in supporting staff (Glass et al., 2016; MacGregor, Wathen, Olszowy, et al., 2016; Swanberg et al., 2007). A gap in the literature can clearly be identified in relation to the needs and experiences of survivor health professionals and the role of hospitals in planning for, and responding to, their survivor staff.

2.7 SUMMARY & JUSTIFICATION FOR THE CURRENT RESEARCH

DFV is a significant contributor to social, emotional and physical ill-health in our community, and hospitals are ideally positioned as key responders to the health sequelae of partner and familial abuse. However, there are several barriers to the uptake and embedding of DFV clinical care by health professionals, and personal exposure to DFV may be one. Of the studies about prevalence of DFV against health professionals, none were conducted in Australia, and several methodological flaws inhibit their generalisability. Further, only a handful of studies have investigated whether personal exposure to DFV is associated with readiness to respond to survivors and the findings were inconclusive and compromised by their limited scope and lack of adjustment in analysis. Finally, hospital employers play a critical role in responding to the needs of their staff, however, as an occupational industry, there is almost no research about how survivor staff want their hospital workplace to support them and what managers in these settings think about the response role. The one study that included health professionals among its participants, showed that the vast majority of those who had discussed DFV at work found that either nothing changed, or a negative outcome resulted (McFerran, 2011). In order to better understand and support survivor women whose profession places them at the frontline of caring for survivors in our community, some unanswered and interesting research questions remain.

In the next Chapter, the methodology applied to answer the research questions of this thesis is detailed. This Methods Chapter includes the theoretical underpinnings of this research, its aim, the study rationale and design, recruitment, data collection and ethical considerations.

3.

Methodology

“We are so focused on the women we care for, that we sometimes forget our work colleagues.”

(Survivor health professional participant)

“I think we're much more familiar with supporting staff through an issue where they've broken a leg, or they need an operation... I'm not too sure that we're all really, sort of, up to scratch in terms of, well, I'm unfit to come to work because I've been bashed by my husband and I'm bruised. I'm not sure whether – well, I've not come across it, so if I've not come across it, it's highly likely other people might not have.”

(Hospital manager participant)

3.1 OVERVIEW

This Chapter outlines the methods used to answer the four research questions of this thesis. Phase One was a cross-sectional survey of health professional women about DFV in personal and professional life. Phase Two involved interviews with key stakeholders and analysis of survivor qualitative data about the role of the workplace in responding to survivor staff. This Chapter begins with the theoretical underpinnings of this thesis, then moves to an examination of the participants, procedure, recruitment processes and methods for analysis of both phases. Ethical considerations informed all aspects of this research and will be canvassed in detail towards the end of this Chapter. To ensure confidentiality of the research site, it will be referred to as the 'recruiting hospital' or 'hospital' throughout the thesis (see page 115 further). The first-person voice will be used to discuss theory and the qualitative analysis process where appropriate.

3.2 THEORETICAL PERSPECTIVES

Four theoretical approaches underpinned this thesis. They informed the research questions, design of the methods, recruitment, management of ethical issues, data analysis and interpretations of this research. The theories discussed below are feminist, trauma-informed, ecological and systems.

3.2.1 Feminist theory

Feminist theory underpinned this thesis and is central to my identity as a woman, clinician and researcher. My feminist perspective recognises gender as a fundamental social division, and violence against women as both a consequence of, and reinforcer, of power (Randall, 2010). My journey as a feminist began during my teenage years and was developed by undertaking Women's studies and Social Work subjects at University. Intersectional feminism has reorganised my thinking about gender as not necessarily the central frame through which women experience and understand their oppression even when they are in a violent relationship (Almeida & Durkin, 1999; McKibbin, Duncan, Hamilton, Humphreys, & Kellett, 2015; Nixon & Humphreys, 2010). Multiple systems of subjugation are experienced by some women concurrently, including race, class, sexuality and disability. Marginalised women may identify more strongly with another oppressive system (i.e. racism) before gender (Nixon & Humphreys, 2010).

Just as there is not one cohesive form of *feminism*, there is no unified concept of feminist research or methodology. Instead, fundamental principles and commonly held characteristics are the infrastructure for feminist research (Skinner et al., 2005). These include a focus on gender and gender inequality and the choice of appropriate research tools. Consciousness of, and action to break down the power discrepancy held by researchers treating participants as passive individuals is also a consistent theme (Skinner et al., 2005). A unifying thread throughout feminist research is to challenge male power (Randall, 2010). The field of DFV is indebted to the value and learning born of qualitative and participatory research that has long voiced the lived experience of survivors (Leung et al., 2019). Indeed, my origins as a researcher are in this method (McLindon & Harms, 2011). However, targets to understand, address and reduce DFV are often expressed in quantitative terms, i.e. prevalence data, and a case for the compatibility of quantitative methods with feminist research can be made (Leung et al., 2019).

Making the case for feminist quantitative research

Leung et al. (2019) argue that a feminist approach to research is essential for understanding how to end DFV, and that quantitative methods are crucial to reaching this goal, assuming core principles underlie its application. Adapted from the International Women's Development Agency (2017), the principles of feminist research espoused by Leung et al. (2019) are that research be: *Ethical, Collaborative, Participatory, Transformative, Intersectional, Accountable, Accessible* and *Open* (Leung et al., 2019). While these principles were catalogued after the onset of my PhD, they are well-established core values of feminist research, and their essence is reflected in the deliberate process I went through to practically apply feminist values to the various phases of my research. Using the Leung et al. (2019) approach as a framework, below, I synthesise how feminist principles underpinned this work (Leung et al., 2019).

Feminist theory informed my decision to study DFV in the lives of health professional women and refined the research questions asked. As a feminist researcher, I was keenly aware of my *ethical* responsibility to minimise the impact of the research on participants, especially given the sensitive and potentially traumatic nature of disclosing IPV, family violence and sexual assault (World Health Organization, 2007). The ethics of this approach to research is addressed further in this Chapter (page 112) (Maynard & Purvis, 1994). I endeavored to be *collaborative* and *participatory* in several ways, including in project development; hospital health professionals contributed to the design, survey construction and interview questions. The aim was always that the research be conducted *with* health professionals and managers, not *on* them (Leung et al., 2019). I strove to take those who would be directly affected by this research on the project journey. I did this by meeting with health professionals (internal and external to the research site) all the way through the project, seeking input about the research gap and perspectives on the research questions they thought were important. I spoke with potential participants at many forums about the purpose of the research, the change it could contribute, and actively sought ideas and responses so that feedback informed the project. I asked health professionals for their input on the survey questions (including during piloting – page 82), and convened meetings during analysis to share outcomes and seek responses from those on the ground.

From the beginning, I was explicit that the aim was for the findings to create *transformation* at the hospital and more broadly within health services. The project sought to create change by breaking the silence about DFV against health professional women; to learn from survivors what they need in order to enhance workplace support for both personal and professional issues related to lived experience, and, in turn, strengthen employment security for survivors. I sought to train every clinical manager and member of the Human Resources (HR) department to prepare for the possibility of increased DFV disclosures at the research hospital (more on this deeper in the Chapter). This training was strengths-based and designed to value and build on the capacity of managers and others to respond to survivor employees sensitively and with evidence-based support. It is possible that this act of training may have led to longer-term change in the future responses towards survivor staff by those who took part in the training, although this was not a question answered by this research.

Being an insider researcher meant that I was particularly conscious of *accountability* to the hospital - my community. I continually acknowledged any disruption caused by the project (signposting this in the survey, research site newsletters and all project discussions/presentations) and sought to mitigate the risks of participation (complete list of ethical issues starts on page 112). My supervisors and I attempted to be *accessible* and *open* in our reporting and interpretation of all the results, not just those that were statistically significant (Leung et al., 2019). Feminist research is politically active; beyond the world of academia, it seeks to change the social structures that oppress women, including by exposing the reality of their lives. To enact this concept, I have attempted to circulate the research findings widely through publication (pages xxi, xxii, xxiii); work that is ongoing (Powell, 2016). Additionally, I have presented and discussed the findings at several forums open to participants and key stakeholders, including the media (page 300).

Reflecting retrospectivity on how this project did or did not enact the feminist principles of Leung et al. (2019), I recognise that it was not *intersectional* beyond acknowledging and seeking (through collaboration and being within the hospital) to break down the power and privilege divide that often occurs between researchers and the researched (Leung et al., 2019). Feminist scholars of colour have critiqued existing theories of DFV as based on gender as the only important factor, arguing that the experience of ethnicity, transgenerational dispossession and trauma, disability and culture all define the experience of trauma and shape its interpretation (Kelly, 2011). The decision not to ask demographic or experience questions specifically targeted to people who identify with a culturally and linguistically diverse background, or as lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual or questioning, or who have a disability, was deliberate. In the staff population at the hospital, such data could be identifying. However, this is an acknowledged limitation to the potential of the project to contribute to better support of people who are often overlooked in research and who face multiple, intersecting oppressions that it should be the goal of research to expose and alleviate (Bauer, 2014). Other theoretical perspectives informed this research, including a trauma-informed perspective.

3.2.2 Trauma-informed perspective

A trauma-informed lens has long influenced my approach to practice, guiding my practice as a sexual assault counsellor (Harris & Fallot, 2001). The thesis of Herman (1992) and others about the impact of trauma on the body instilled understanding about the injurious effects of terror and pain on the experience of traversing the external world within the inner experience of the body after trauma (Briere, 2006; Levine, 1997; Rothschild, 2000; van der Kolk, McFarlane, & Weisaeth, 1996). Herman (1992) characterises the trauma response as fluid, rather than static, and on a (non-linear) path towards recovery. A trauma-informed approach starts with an awareness of the commonality of trauma, the silence and shame with which it is synonymous, and the meaning of physical and psychological safety (Harms, 2015). It is an approach to recovery aimed at restoring control and safety through every interaction with a person, organisation or system (Harms, 2015). While trauma-informed practice has advanced within mental health and human service systems in Australia (Quadara, 2015) and overseas (Hopper, Bassuk, & Olivet, 2010), to date, it has not been a framework conceptualised for Australian hospitals. Looking through a trauma-informed lens framed my thinking in multiple ways, including through the principle that the possibility of trauma is in everyone's lives regardless of their job (Quadara, 2015). Trauma can have a centralising influence across survivors' future experience of the world. Using this lens, the common systems with which survivors interact, including their workplace, are important to understand and seek to strengthen (Reeves, 2015). A trauma-informed perspective was critical to the conceptualisation of an exemplary response by a hospital to both its staff and patients, and this will be developed further in the Implications and Conclusions final Chapter.

3.2.3 Ecological & systems perspective

An ecological and systemic understanding of DFV and contributing factors was foundational to the approach of this research (Bronfenbrenner, 1992; Heise, 1998, 2011). These theories were threads that ran through how DFV was defined, the choice to investigate violence by multiple people (intimate partners, family members and others) across the life course, including witnessing parental violence, and the context of understanding employment as a central system with which individuals are engaged. Bronfenbrenner (1992) created a model of concentric circles to understand the layered systems in which people live their lives, from the micro to the macro. Heise (1998) developed this model further as a way of understanding the origins of DFV, its prevention and healing for survivors. At the centre of this model sits a woman with her range of experience, including witnessing violence growing up and violence directed at her as a child. Circling around that layer is the microsystem in which the woman's relationships take place, where attitudes that accept violence as a means of resolving conflict reside and where the male may be head of the household and in control of wealth, with greater opportunities for financial security. Enclosing the microsystem is the exosystem, holding the power disparity between men and women resultant from women’s relative lack of access to resources, rigid gender roles and concepts that link masculinity with toughness and dominance. Health professionals, whose job it is to identify and intervene with patients, are employed within a workplace when they perform this role. A person's workplace, a site an employee spends much of their time, is a significant component of one's exosystem (Bronfenbrenner, 1992). The overarching layer of these circles is the macrosystem, in which gender inequity is evidenced through composite measures and social, economic and cultural factors are in operation (Heise, 1998, 2011). Each of these systems interact and there is no single path through them. Heise (2011) revised this model to indicate the strength of the evidence for each layer a decade ago and a detailed model depicts seven layers centred around a woman: intimate partner violence, conflict arena, relationship, male partner, community and macrosocial (Heise, 2011).

Further to a systems perspective, the health system is regarded as an important area of investigation because development of this system is crucial to a multisectoral response to DFV (García-Moreno et al., 2015). Within the international health system to DFV response as set out by García-Moreno et al. (2015), the need for health systems to support their health professionals is central to those health professionals being able to provide the best care to survivor patients (Figure 2). The thesis of the health system response is that no matter which model is used to deliver healthcare to women, a functional health system is required to ensure that it is effective and safe for women (García-Moreno et al., 2015). Taking this approach further, it would seem that supporting the mostly female workforce of a health system should go beyond just the care of survivor patients. The implication being that health professionals’ readiness to provide the best care to women is likely to be enhanced if the health system can support survivor staff and respond to their needs.

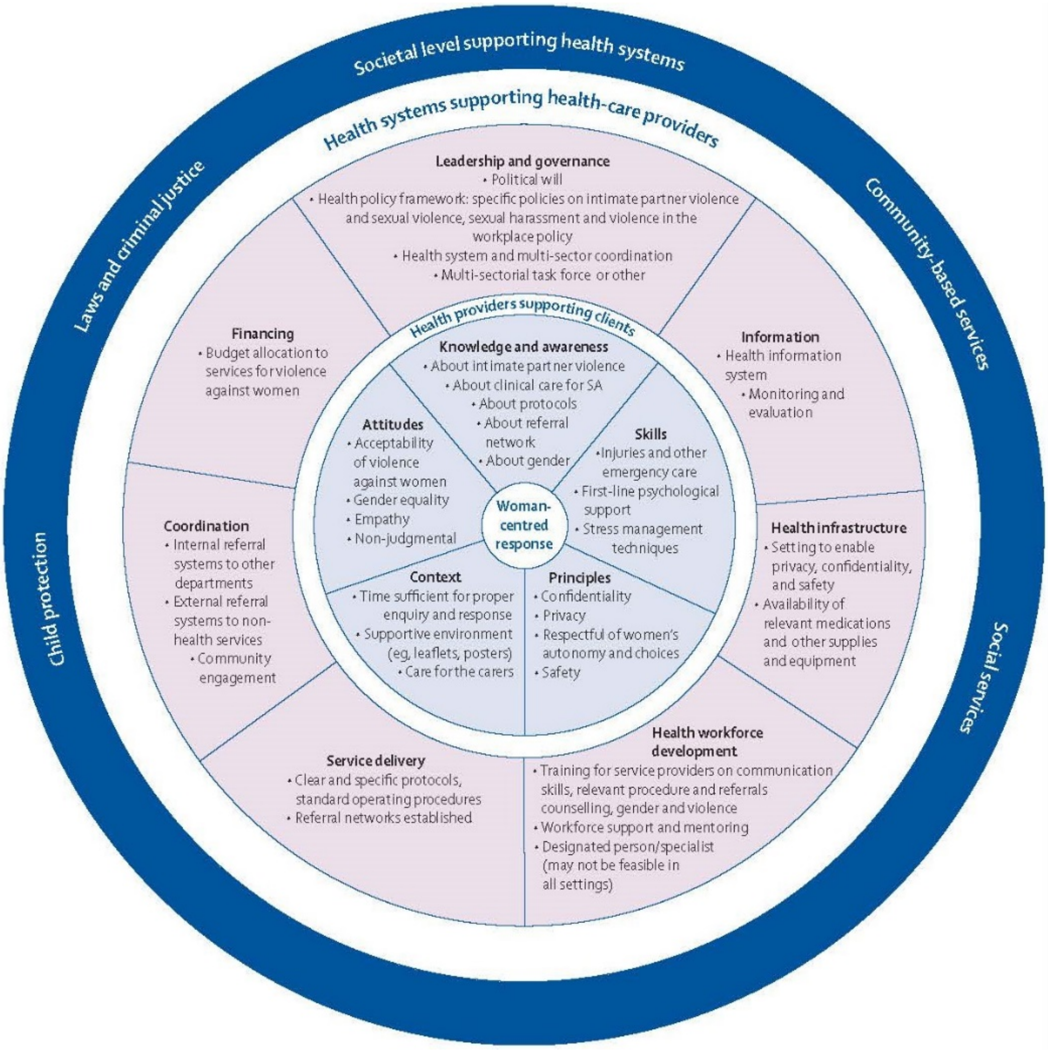

Figure 2. Elements of the health system response necessary to address DFV
(García-Moreno et al., 2015, p. 1570)

The inter-relationship between theories

The four theoretical approaches that underwrote this project were inter-related in several ways. Shared characteristics among the theories acted as cross theoretical bridges, together influencing the research questions, methodological approach, engagement with participants, approach to ethical issues, analysis, interpretation and translation of findings. The relationship between the theories and their shared characteristics are depicted in Figure 3.

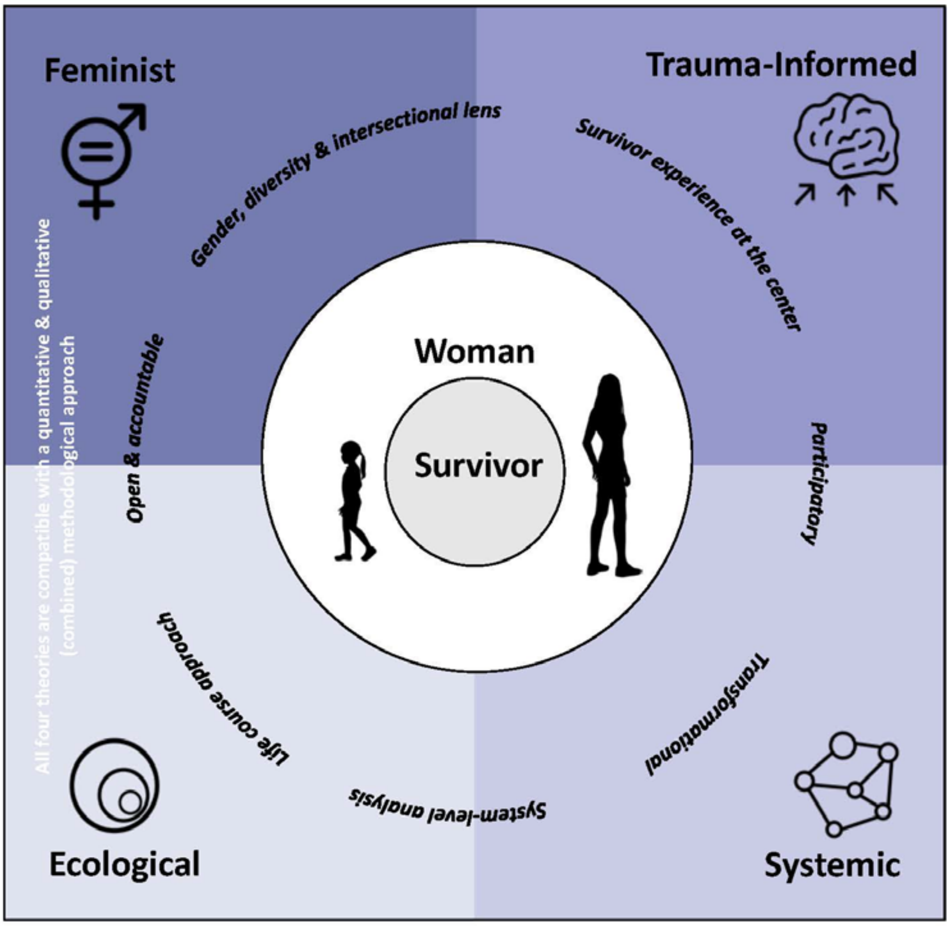

Figure 3. Inter-relationship between theoretical approaches

The combined methodological approach that is utilised in this thesis will now be canvassed (Halcomb, 2019).

3.3 COMBINED METHODOLOGICAL APPROACH

Employing both quantitative and qualitative methods to collect data towards a broad aim, this project utilised what Halcomb (2019) refers to as a "combined approach". A combined methodological approach uses qualitative and quantitative data to answer different research questions. Applying a combined approach, quantitative and qualitative data were used together in this project, and connections between the survey and interview findings were explored. However, unlike in mixed-methods research, distinct types of data were not fully integrated to answer the research questions (Halcomb, 2019, p. 4). Within this PhD, the quantitative and qualitative data sets were collected independently, and there was limited interaction between them until the analysis phase. Specifically, the interaction between the two data sets included the interview schedule asking questions of key stakeholders that took as their starting point the preliminary findings of the quantitative data with survivor health professionals. However, the combination of the two types of data was not required to corroborate the findings across methods or clarify the results of one method (Bryman, 2007).

A combined approach is distinct from a ‘mixed-methods’ project. Referred to as the “third research paradigm” (Johnson & Onwuegbuzie, 2004, p. 14), mixed-methodology emerged in the 1980s, characterised by several distinct features, most importantly the integration of two or more methods to answer research questions, that interact in the analysis (Bryman, 2007; Creswell & Plano-Clark, 2011). There are at least four aspects to research where a combined and mixed-method approach can be distinguished (Halcomb, 2019). First, is the degree of interaction between the different types of data; second, the design of an implementation sequence; third, whether priority is given to one type of data over the other; and fourth, whether different data is truly integrated and the timing of integration (Halcomb, 2019). Mixed-methods research has several advantages in the pursuit of better understanding DFV, since experiences and responses to relationships are inherently complex and multifaceted (Testa, Livingston, & VanZile-Tamsen, 2011). However, a legitimate argument has been made that there is little scope to do robust mixed-methods research within the time and resource constraints of a PhD (Halcomb & Andrew, 2009). Common consequences stemming from these constraints include dual data that is either not integrated, or integrated to only a limited extent (Bryman, 2007). These were serious considerations for this PhD project. A combined approach, as opposed to a mixed methods study, seemed a good fit for this project. A combined approach facilitated the collection of different types of data to answer our research questions: to understand prevalence, impacts and experience to inform implications, without the obstructions familiar to PhD mixed-methods research.

Project panel

A project ‘panel’ (rather than a reference group) advised on aspects of the research including the projects’ central questions, study design, practical issues to do with methodology, data analysis and interpretation of the findings. This panel consisted of my two PhD supervisors and a Social Work manager at the recruiting hospital (since retired from the recruiting hospital), herself a practitioner and Masters-level mixed-methods researcher with extensive experience working with survivor women. The fourth panel member was a Midwife Academic with experience in quantitative research in a tertiary health setting, as well as intimate knowledge of the recruiting hospital. Finally, an Academic in the Department of General Practice chaired the panel meetings, herself a researcher with expertise in women's health and healthcare. The panel met several times within the first year of the project and annually thereafter, or more frequently, to guide the project as the need arose.

3.4 RE-STATEMENT OF AIM, RESEARCH QUESTION & HYPOTHESES

In the previous Chapter, an argument was mounted for the lack of robust, recent and nationally relevant evidence about the prevalence of 12-month and lifetime IPV and lifetime DFV against female health professionals in Australia. Additionally, the research about whether health professional's personal history of DFV is associated with their clinical care of survivor patients is sparse and equivocal. Finally, it was established that little information exists about how survivor health professionals want their workplace to support them, and what hospital managers and other key stakeholders think the response of a hospital workplace should be. To address this research gap, the overarching aim of this study was to investigate the prevalence of DFV against a population of Australian health professionals, to understand whether aspects of clinical care are associated with exposure to DFV, and to explore the views of survivor health professionals and key stakeholders about the role of the workplace in responding to staff who have experienced DFV. In response to this aim, four research questions were posited. Phase One of the research was designed to answer questions one and two:

(1) *What is the prevalence of DFV and other interpersonal violence in an Australian health professional population?*

(2) *Do health professional's personal experiences of DFV affect their attitudes about DFV, comfort to discuss the issue with women, enquiry and response toward survivor women?*

To answer research question two, it was hypothesised that, after adjusting for possible confounding background variables, compared with their non-abused peers, survivor health professionals would: 1) demonstrate more sensitive attitudes about survivors; 2) feel more comfortable discussing DFV and sexual assault with their patients; 3) ask more patients about DFV; 4) identify more survivor patients within the most recent six-month period; and 5) provide more DFV interventions to survivor patients, including DFV referral.

Phase Two of this project answered research questions three and four:

(3) *What support needs do survivor health professionals have of their hospital workplace?*

(4) *What are the views of key stakeholders about the role of the workplace in responding to staff survivors of DFV?*

3.5 RESEARCH DESIGN

To answer the four research questions, two data types were collected during two project phases (Figure 4):

1. An online and paper cross-sectional survey recruiting a whole population of health professionals at one tertiary hospital;
2. Individual and group interviews with key stakeholders involved in the employment of health professionals, i.e. executive, directors, managers and HR staff at the same tertiary hospital used for survey recruitment, as well as Union and Employee Assistance Program leaders external to the hospital.

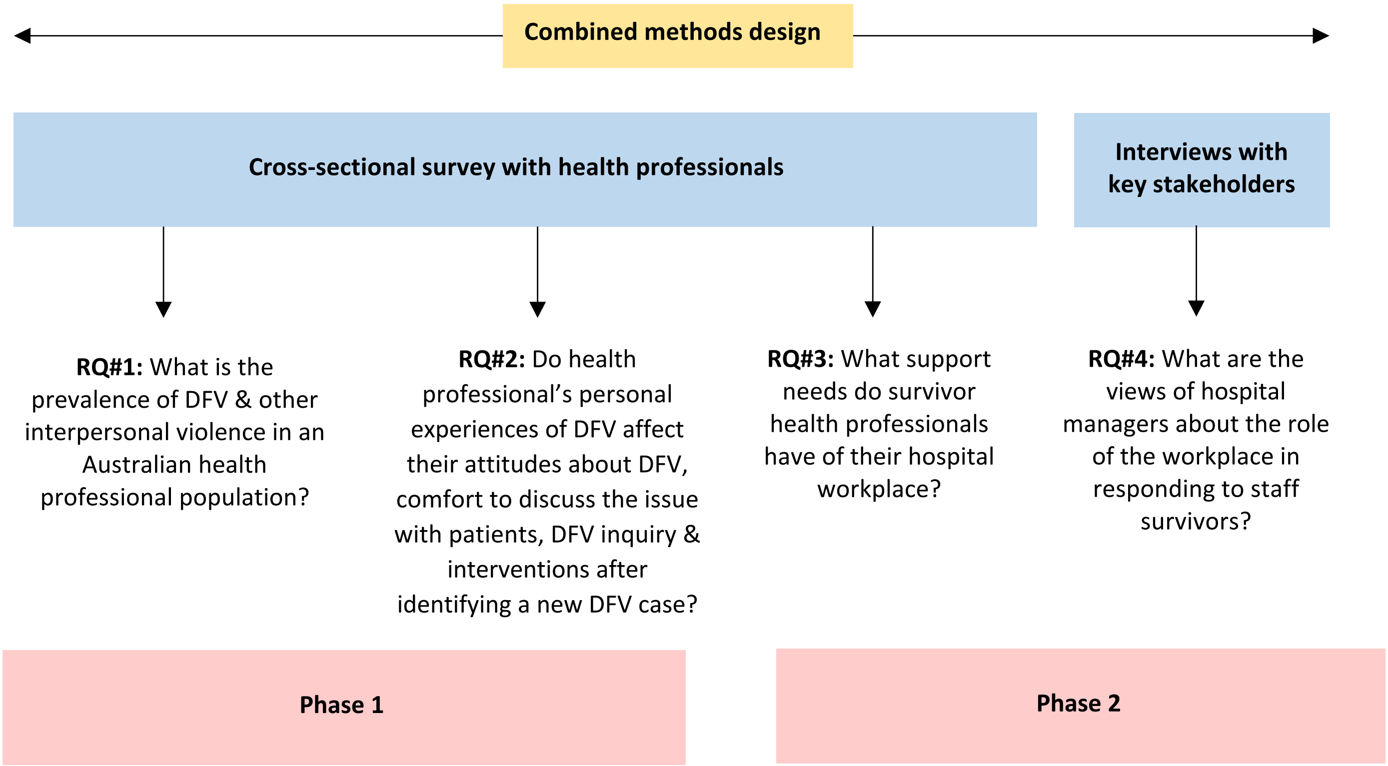

Figure 4. Research design

3.5.1 Research setting

The survey and most of the interviews occurred at a single recruitment site: an Australian tertiary maternity hospital. Located in an inner urban area, the hospital cares for women and babies with complex medical conditions utilising a multidisciplinary approach. The hospital's catchment area includes a significant number of women from disadvantaged socio-economic, educational and skill backgrounds. The majority of clinicians at the recruiting hospital are women. The main clinical background is nursing and midwifery, followed by medicine and allied health, of which social work is by far the largest professional group. The clinical philosophy of the hospital is the social model of health, which recognises that social and cultural determinants affect people's health and wellbeing (Wilkinson & Marmot, 2003). At the time of recruitment, the hospital had a 'whole of hospital' *Violence Against Women Strategy*, and DFV was a priority area in the strategic plan. This strategy had evolved over the previous two and a half decades, with the hospital recognised as a leader among hospitals because of their systems-level approach to DFV. A Clinical Practice Guideline (CPG) underwrote identification, response and referral to DFV and a calendar punctuated with DFV training events encouraged health professionals to bolster their clinical skills. The hospital had an internal departmental policy that social workers screen all patients for DFV, documenting the outcome in the patient medical record. However, no specific funding or resources were allocated to DFV within the hospital. In the main, work in this space relied on a diverse handful of particularly motivated individuals and in-kind support from the social work department, who for example, developed the CPG and facilitated all training. At the time of this research, a discourse about survivor staff had not yet begun, nor were there formal pathways for survivor staff support or resources.

The next section will cover Phase One's quantitative method: development of the cross-sectional survey with health professionals, participants, procedure, recruitment and analysis. This will be followed by the methods for Phase Two: analysis of the qualitative survey questions completed by survivor health professionals and interviews with key stakeholders.

3.6 PHASE ONE: CROSS-SECTIONAL SURVEY

Research questions one, two and three were answered by an online and paper cross-sectional survey developed for this project. The survey built upon previous work on the topic of DFV against health professionals, utilising a validated measure to assess the prevalence of violence (Hegarty et al., 2005).

3.6.1 Rationale for the survey method

Cross-sectional surveys are an evidence-based method for measuring prevalence and recognising associations using standardised questions (Devries et al., 2013). Prevalence estimates are a significant tool in understanding the scope and magnitude of DFV against specific populations, allowing surveillance of trends and patterns over time (Burton & Blair, 1991; Devries et al., 2013; Kirkwood & Sterne, 2003). Due to their anonymity, survey methods have a long history of being used to investigate sensitive and stigmatised topics (Braun & Clark, 2013). Consistent with the findings of a systematic review about methods to increase the detection of DFV, it was determined that for this PhD study, a paper or electronic survey may result in more comfortable and candid participation and a broader range of views than face-to-face survey delivery (Hussain et al., 2015). Online and paper surveys are a standard vehicle for social, behavioural and health research and can be a useful tool with participants who spend work and other time on a computer (Rhodes, Bowie, & Hergenrather, 2003). A decision was made to offer dual methods - online and paper - of survey completion to ensure that people without access to a private computer had the option to participate via a paper survey.

Upon consideration, other research methods did not seem the right fit for this project. For example, a wholly qualitative study involving interviews, while a typical design for a feminist study, would not have been the right method to establish prevalence of DFV against health professional women, nor the relationship with aspects of clinical care. Ethical issues were also a significant factor in any consideration of a face-to face research design to answer questions about DFV experience given that recruitment would have occurred in the workplace by a potential colleague (see more on page 112) (Hussain et al., 2015).

3.6.2 Survey development

The survey of clinical health professionals was titled, *The Women Against Violence (WAV) Project* survey. This section of the Chapter provides an overview of the survey and its development, including pilot testing. The section then moves to give an account of participants, followed by the survey procedure. As will be discussed in more detail below, there was a commitment to maximising the response rate (page 84) and minimising negative implications of participation (i.e. onerousness, distress) (page 112). A detailed definition of each of the survey predictor, outcome and confounding variables is provided further in the Chapter (page 90).

Development of the survey took the first eight months of candidature. In line with the principles of good survey design, it matured through discussions with experienced researchers, immersion in survey theory, a review of the literature and investigation of validated tools (Gomez-Fernandez et al., 2019; Iarossi, 2006; Umbach, 2005). The starting point for constructing *The WAV Project* survey was defining the specific research questions it would provide the vehicle to answer. Validated scales were used where possible and will be detailed later in this Chapter, otherwise bespoke items were constructed using principles of good survey design (Iarossi, 2006; Jamieson, 2004;

Lockerbie & Lutz, 1986; Umbach, 2005). It was determined that bespoke survey items were warranted where a validated scale for a particular topic could not be located, or because of problems with an available measure significant enough to prevent inclusion.

Principles of survey design were applied to both survey construction, pre-testing and analysis (Iarossi, 2006; Jamieson, 2004; Lockerbie & Lutz, 1986; Umbach, 2005). The main goal in understanding and employing these principles was the reduction of measurement error (Umbach, 2005). The same key terms were used throughout the survey, based on the language used to describe DFV at the recruitment site with which respondents were familiar, which was VAW (Lockerbie & Lutz, 1986). To ensure the integrity of questions, they were constructed so that the prescribed options were both mutually exclusive, exhaustive and absent of bias (i.e. avoiding the use of words with positive or negative connotations) (Iarossi, 2006). Items were based on the principle that they should not exceed 20 words or contain more than three commas (Iarossi, 2006). Bespoke survey questions were repeatedly checked for clarity, objectivity, simplicity and specificity (Iarossi, 2006; Lockerbie & Lutz, 1986).

Following the recommendations of Lockerbie and Lutz (1986), Jamieson (2004) and others, an odd number of categories were utilised in ranking scale questions, designed to have between five to seven points, with the middle made neutral (i.e. '*neither agree nor disagree'*) (Emerson, 2017; Iarossi, 2006; Lockerbie & Lutz, 1986). The purpose of setting up a ranking scale question in this way was to avoid a respondent with no views on the matter in question feeling forced to either answer inaccurately or miss the question (Iarossi, 2006; Lockerbie & Lutz, 1986). To this end, the category of '*other*' was incorporated where necessary, with participants invited to qualify their selection using the statement: '*Please specify'* (Lockerbie & Lutz, 1986).

With regard to recall bias, items about self-reported clinical practice employed a six-month recall timeframe where possible since this is considered more reliable and less cognitively arduous than extended periods (Burton & Blair, 1991). However, where a validated measure was incorporated, the survey conformed to its recall period, for example, the 12-month CAS. The final point to conclude this discussion of how the principles of good survey design informed construction of *The WAV Project* survey, is the decision that demographic information would be placed at the end of the survey. This adhered to the recommendation that less onerous questions be placed at either the beginning or end of a survey (Iarossi, 2006). It was hoped that having completed most of the survey by that point, participants might also feel enhanced trust to provide demographic information. Information about support services was placed after the final question in the survey.

3.6.3 Overview of survey sections

The final survey (Appendix B) consisted of six sections encompassing twenty-nine questions with forced-choice answers (Likert-type ranking scale or yes/no) and two open-text questions. The survey topics were: DFV exposure (12-month IPV, adult lifetime IPV and lifetime DFV), other interpersonal violence, DFV work-related impacts, attitudes about survivors and the hospital, clinical care of patient survivors and demographic items. Participants had the option of adding additional comments regarding any issue raised by the survey at the end. It was estimated to take fifteen or more minutes to complete. Table 8 presents a description of each survey section and all survey variables are detailed below. Two open-ended questions were included to elicit richer survey data about participants' experiences, discussed in Phase Two.

Table 8. Survey sections

Survey section		Description
A	Violence Against Women Training	Professional training (any) about DFV
B	Your Opinions	Attitudes about survivor patients and the response role of hospitals
C	Your Practice & the Hospital Environment	Comfort discussing DFV with patients; DFV enquiry; identification and interventions with survivor patients
D	Your Relationships	Personal exposure to DFV, particularly focused on IPV during the last twelve months
E	Workplace Support	Workplace support for DFV
F	Information About You	Demographics including age, professional background and years of clinical experience

3.6.4 Pilot study

The survey was piloted with health professionals not employed at the hospital using a convenience sample (*n* = 10). Research suggests that pre-test sample sizes of between 10 and 15 people are enough to uncover error (Lockerbie & Lutz, 1986). Pilot participants were asked for feedback about their experience of undertaking the survey, particularly in terms of their reaction to questions, their comfort level by the end of the survey, question clarity and comprehensiveness, topic flow, ease of completion, layout, appeal and time taken (Lockerbie & Lutz, 1986; Umbach, 2005). Outcomes from the pilot altered the survey, particularly in terms of length and the wording of questions.

3.7 SURVEY PARTICIPANTS

All health professionals working in a clinical capacity at the time of the project were invited to participate in Phase One: the survey. Participants were recruited at the hospital in their role as a nurse, midwife, doctor or allied health professional working clinically part or full time with patients and/or supervising clinical staff. Allied health professionals included social workers, physiotherapists, nutritionists and psychologists. It was not possible to separate allied health professionals, because this could be identifying for smaller allied health groups. People were excluded from participating if they were non-clinical staff, on one or more months of leave during the data collection period or employed casually. The demographics of clinical employees at the hospital implied a tertiary-level qualification and reasonable English language skills so the survey was only offered in English. Consent to participate was implied through survey submission.

3.8 SURVEY PROCEDURE

Two different methods of survey completion were offered to participants. The first was online via the internet platform Survey Monkey (Survey Monkey Inc, 2018). The second was a paper (hard copy) version. Experts experienced in all-staff surveys at the recruiting hospital suggested dual methods of data collection. The rationale was that some hospital staff might not have access to a private computer, or only access their workplace email sporadically. All eligible employees at the hospital were first emailed an online survey. Eligible employees who did not complete a survey electronically were subsequently sent a paper version.

Personalised communication with potential participants

To assist with confidential and personalised recruitment, an employee of the hospital's HR department assumed a third-party recruiter role. The third-party recruiter (hereafter referred to as the 'recruiter') was practised in the administration of whole-staff surveys at the hospital and had Masters' level academic research training. The time the recruiter spent assisting the project was bestowed to the project as in-kind support from the hospital.

The recruiter began by randomly assigning a unique, non-identifiable identification (ID) number to eligible employee email addresses. The purpose of using ID numbers was two-fold; to personalise participant correspondence without anyone, including the recruiter, being aware of the names and identities of participants, and to control for the unlikely potential error of participants mistakenly submitting a survey twice. Personalised correspondence ensured that only participants yet to submit a survey received a reminder, and the link embedded in those reminders allowed participants to continue their survey from where they left off. Personalised correspondence allowed the reduction of unnecessary email traffic away from those who had submitted a survey and is associated with higher response rates (Edwards et al., 2010). Only the recruiter had access to the ID numbers; they were strictly confidential, including from the researchers. To ensure the confidentiality of the survey data, it was not accessible to the recruiter, and was collected and accessible to the researchers absent of any identifying information (Survey Monkey Inc, 2018).

3.9 SURVEY RECRUITMENT

Sample size calculation

We were surveying a whole population of clinical staff at the recruiting hospital (N=1,223). Based on previous whole-staff surveys, the response rate was estimated to be 30% (minimum) (B. O'Brien, personal communication, 1 August 2012). Based on a two-sample test of proportions, we determined that a sample size of ~n=360 should be sufficient to detect meaningful differences between participants on variables of interest with at least 80% power and a 5% significance level.

3.9.1 Maximising the response rate

Methods to maximise the survey response rate were undertaken in an effort to ensure the sample was as representative of the hospital's clinical staff population as possible. Based on a Cochrane Review of methods to increase survey participation, approaches employed in *The WAV Project* included: dual data collection methods, displaying the University brand, pre-notification, personalised contact, direct communication assuring confidentiality and follow up notification with another copy of the survey (Edwards et al., 2010). The project had a recognisable identity, a non-conditional gratis incentive and awareness about the project was increased through posters and multiple meetings with clinical teams, managers and executive at the hospital. Many of these dimensions to maximising the response rate will be discussed further below.

Project branding & communication

An identifiable brand was created using the project title (Figure 5). The University prohibits the creation of logos for individual research projects; instead, font and colour were used to create a project identity, alongside the University of Melbourne and recruiting hospital's logos. Branding was applied to all project materials and presentations. The electronic survey incorporated the project colours (Appendix C). Produced by a professional printing company, the paper version of the survey was presented as an A5 booklet with a coloured card cover and greyscale paper content (Appendix B). Project posters encouraging staff participation were placed in staffrooms during recruitment (Appendix D). Three different stories about DFV and *The WAV Project* were published in the staff newsletter (unable to include in Appendix to maintain research site anonymity); the first during the same week as the primer email was sent. Webpages for *The WAV Project* were created to refer people for extra project information, resources for support and contact details. These pages were nested within the Department of General Practice, University of Melbourne website.

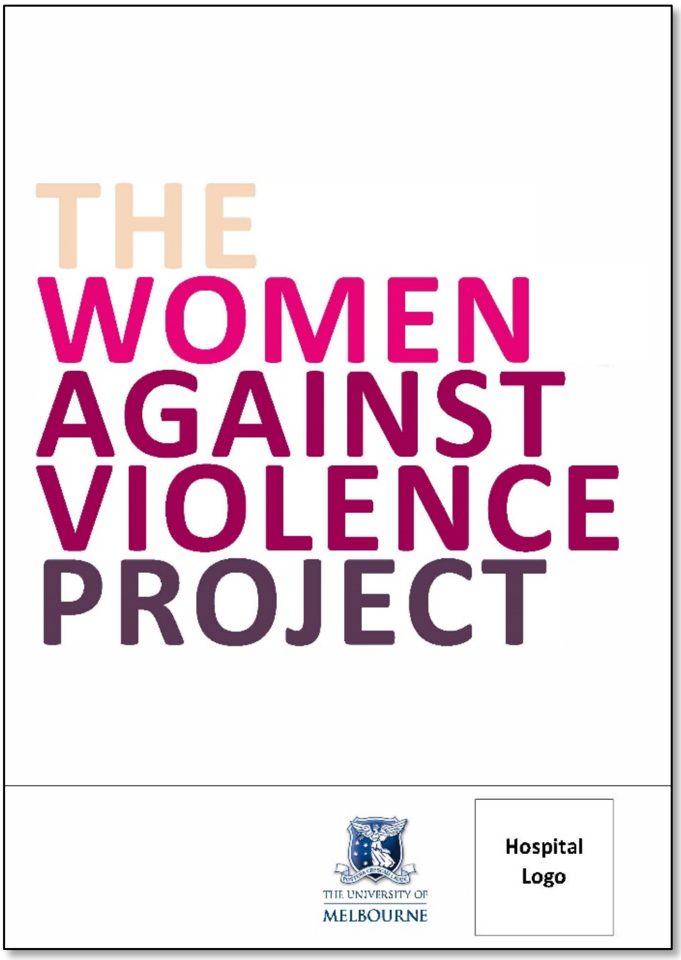

Figure 5. The WAV project branding

Survey 'Roadshow'

Aimed at increasing awareness about the project and maximising the response rate, I engaged in a "roadshow" of presentations around the hospital in the weeks leading up to recruitment, including a 60-minute hospital "Grand Round". Encompassing 23 clinical team meetings and handovers around the hospital, I spoke to hundreds of eligible participants about involvement and the long-term goal of the project: enhanced understanding and support for health professional staff. I asked people for their questions, ideas and feedback. These presentations typically lasted 10-15 minutes each.

Support from hospital executive, clinical directors and management was critical to both minimising any challenges to project participation for health professionals and preparing the hospital for a possible increase in discussion about DFV and disclosures. In this context, I met several times with the hospital CEO, the Executive team and management to outline the project, expected outcomes, and to provide updates, answer questions and address risks to participants.

Non-conditional coffee gratis

To show appreciation for health professionals who considered taking part in the survey, a modest, non-monetary, unconditional incentive was offered: a coffee/hot drink voucher redeemable at the hospital café (unable to include in Appendix to maintain research site anonymity) (Edwards et al., 2010). An electronic voucher accompanied the introductory email, both reminder emails and a physical voucher were enclosed with the paper version of the survey. Potential participants were invited to print the electronic voucher and redeem it anonymously at the hospital café regardless of whether they participated in the project or not. In addition to wanting to show gratitude to potential participants for gifting their time and experience to the project, research in the USA with *N*=397 survivors of childhood cancer found that an unconditional and immediate incentive accompanying a mailed survey yielded significantly higher response rates than an incentive conditional upon return of a mailed survey (Rosoff et al., 2005). To increase the affordability of providing this gratis, given the project was unfunded, the acting CEO of the recruiting hospital authored an ultimately successful letter of support to the privately-owned hospital café asking them to donate a portion of the cost of several hundred hot drinks. The café agreed to contribute $1.10 out of every $3.10 small hot drink redeemed by project participants, thereby selling vouchers to the project for the reduced cost of $2.00 each. In total, 440 vouchers were redeemed by potential participants. Both supervisors financially supported the cost of the redeemed vouchers.

3.9.2 Process of recruitment

A recruitment communication strategy was developed in consultation with key people at the hospital, including the CEO (Acting) and recruiter (Figure 6). A week prior to the onset of recruitment, 1,223 eligible employees were sent a primer email (Appendix E) with information about the project, website details and the coffee voucher.

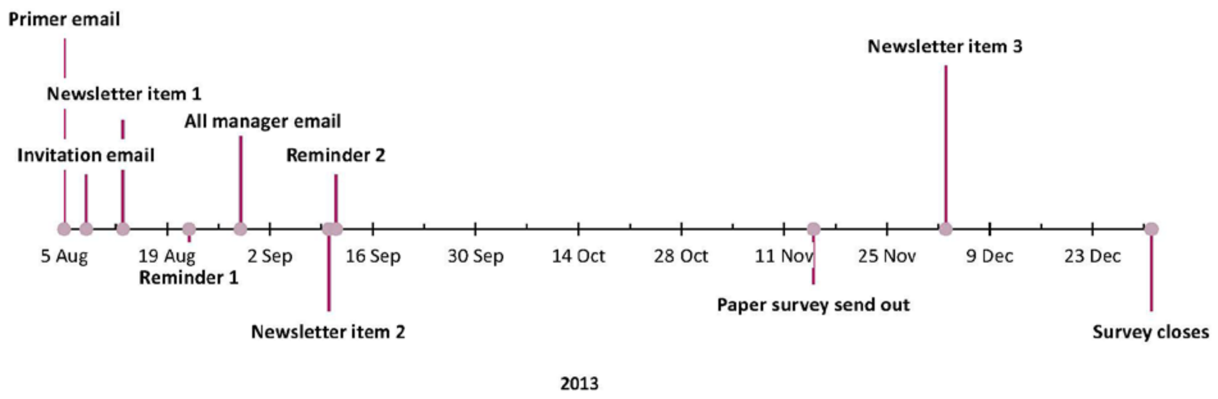

Figure 6. Recruitment communication

The primer email was authored by the hospital CEO (Acting) and endorsed staff participation in the upcoming survey during work hours. When recruitment began, eligible employees were sent an introductory email authored by the research team inviting voluntary and confidential participation (Appendix F). The project Plain Language Statement (PLS) including DFV resources were attached (Appendix G). Prospective participants were encouraged to direct any questions or concerns to a project phone number or email address (housed within the hospital website domain). A reminder email was sent at one- and three-weeks post recruitment commencement to those employees yet to submit a completed survey (Appendices H, I). During this period, the CEO (Acting) sent an email to all clinical managers encouraging them to enable conditions that would allow staff to participate in the survey during work hours if they chose (Appendix J). 417 health professionals returned a completed survey electronically.

3.9.3 Paper version of survey

The second phase of the recruitment strategy was to send a paper version of the survey to the 776 eligible employees who did not submit a survey electronically. This included 15 participants who had electronically submitted a largely incomplete survey. The researchers were not involved in the second phase recruitment process to ensure the confidentially of participants. The volunteer service at the recruiting hospital agreed to prepare project envelopes. The volunteers were neither employees of the hospital or members of the research team. The recruiter compiled a list of the pay points for eligible employees. Using this list, volunteers assembled envelopes addressed to eligible employees by name and pay point. An employee's pay point is the physical hospital location where they receive mail, including timesheets and payslips. Enclosed in each project envelope was a cover letter authored by the researchers (Appendix K), a paper version of the survey (Appendix B), a PLS specific to the paper version of the survey (Appendix L), a coffee voucher and a reply-paid envelope (paid for by the Department of General Practice, University of Melbourne). Volunteers gave the prepared envelopes to the hospital mailroom for delivery to eligible employees. 125 participants had returned a paper version of the survey by the end of the recruitment period six weeks later, bringing the total sample to 527 participants (response rate 44.7%). Figure 7 displays the flowchart of participation.

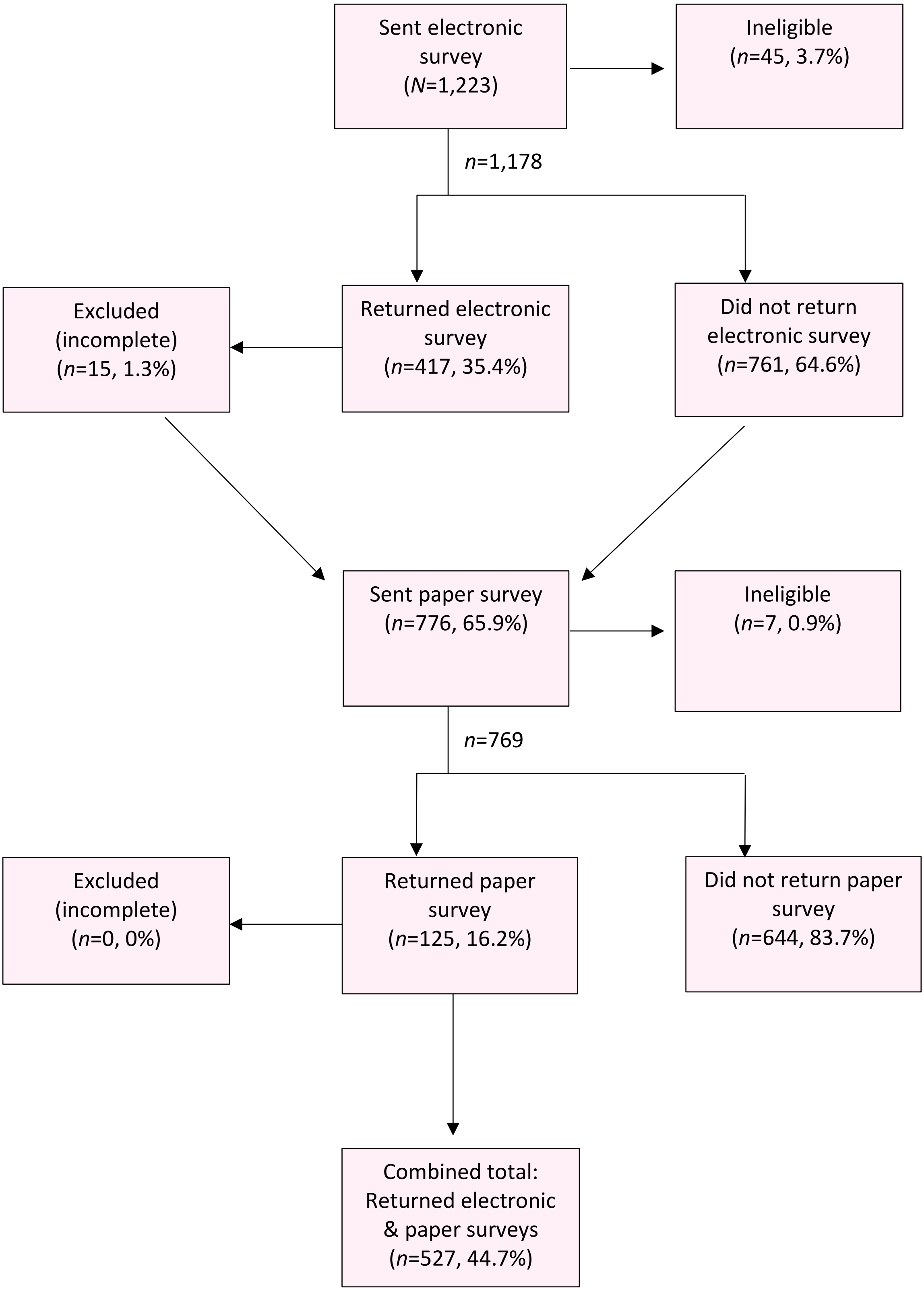

Figure 7. Flowchart of participation

Of the 527 respondents, 471 were female, 40 were male and 16 did not state their sex. The proportion of female to male participants was representative of the gender demographics of the hospital more broadly. However, the number of male participants was ultimately not high enough to have adequate power for statistical analysis, so, regrettably, the male responses and those of people who did not state their sex, had to be omitted from analysis.

Data entry

Data from the electronic survey was collected by Survey Monkey (Survey Monkey Inc, 2018). To ensure one complete data file, as paper surveys were returned, I entered the data straight into Survey Monkey (Survey Monkey Inc, 2018). To ensure accuracy of the data entry, a random selection of 20% of all surveys entered were checked. Two instances of minor data entry error were identified. In consultation with supervisors, it was determined that this error rate did not warrant further checks.

3.10 SURVEY VARIABLES

Before analysis, several new variables were constructed by collapsing or combining original variables (Kirkwood & Sterne, 2003). Variables were identified as exposure (predictor), outcome, confounding, or other, and their management for the purposes of analysis will now be detailed.

The primary predictor variable for this thesis was personal exposure to DFV. In a follow-up analysis, the predictor variables were DFV training and demographics. Outcome variables were: attitudes about DFV, comfort discussing DFV, DFV enquiry, identification and interventions with survivor patients. Additional variables were selected for inclusion in the analysis on the basis that they may be confounding: age, professional background, DFV training and years of clinical experience (more information on page 101). The convention for coding was followed; the absence of a characteristic was marked 0 (the *baseline* or *unexposed* group); the presence of a characteristic was labelled 1 (the *exposed* group) (Kirkwood & Sterne, 2003). Table 9 presents variables that were included in the analysis and their page location in the survey (Appendix B).

Table 9. Variables included in analysis

Exposure (predictor) variables	Description [a]	Survey page
Exposure to 12-month IPV	30 CAS items (*Never, Only once, Several times, Once/month, Once/week, Daily),* categorised using 4 subscales with possible score between 0-150	12-13
Exposure to lifetime IPV	30 CAS items (*Happened more than 12-months ago*), categorised using 4 subscales with possible score between 0-30	12-13
Exposure to DFV	7 items: Lifetime fear of partner / 12mth CAS score ≥3 / Lifetime SCA / Lifetime Physical Abuse in combination with Emotional Abuse / Lifetime CAS score >7 / 2 family violence questions	11-13
DFV training [b, *]	1 item assessed graduate and postgraduate DFV training history (<8 hours [b] / >8 hours) [c]	4
Demographics [d]	3 items assessed: age (< 40 years / >40 years), professional background (medical / nursing / allied health), and years of clinical experience (<10 years / >10 years)	18-19
Outcome variables		
Attitudes [e]	12 PREMIS items comprised two subscales; ‘Victim understanding’ (attitudes about survivors) and ‘Workplace issues’ (attitudes about the role of the workplace). Scoring occurred via a 7-point Likert-type scale, with some items reverse scored due to intentional negative wording	5-6
Comfort discussing DFV [*]	4 items scored on a 5-point Likert-type scale measured comfort to discuss DFV and sexual assault with patients (‘comfortable’ / ‘uncomfortable’)	7
	4 items scored on a 6-point Likert-type scale measured: ‘*Did not avoid issue of DFV*’, etc (all four items specified on page 99) (‘agree’ / ‘disagree’). Some items reverse scored due to intentional negative wording	15
DFV enquiry [*]	1 item scored on a 5-point Likert-type scale measured frequency of asking all patients about DFV (‘never’ / ‘ever’) during the previous 6-months	8
	5 items measured identification of 1+ new patient survivor/s (‘0 new cases’ / ‘1+ new cases’) in the previous 6-months	9
Interventions after identifying a new DFV case [*]	10 items scored on a 5-point Likert-type scale measured: risk assessment, safety planning, case file documentation, use of clinical guideline, access of DFV information to give to patients, clinical discussion at team meeting and with manager, and DFV referrals (‘never’/‘1-3+ times’) during the previous 6-months	8
Variables used for adjustment [*]		
Age	> 40 years	18
Professional background	Allied health: social workers were the most common allied health professionals at this hospital, and it was anticipated that they would likely have been in receipt of greater undergraduate and professional DFV training	18
DFV training	> 8 hours	4
Years of clinical experience	> 10 years	19

Notes

This table is based on Table 1 in manuscript 2 (McLindon et al., 2019, p. 3)

[a] All items were made into binary variables unless otherwise noted

[b] Training also analysed as an outcome (dependent) variable

[c] Participants with no DFV training were included in ‘<8 hours’

[d] Demographic measures modelled on recruitment site specific data & Australian Institute of Health and Welfare (2016b)

[e] Attitudes measured via PREMIS (Short, Alpert, Harris Jr, & Surprenant, 2006)

[*] Bespoke item developed for the survey based on an extensive review of the literature

3.10.1 Predictor variables

Composite Abuse Scale 12-month

The CAS was employed as a validated measure of the prevalence of exposure to IPV (Hegarty, Sheehan, & Schonfeld, 1999; Hegarty et al., 2005). Authored by one of my two PhD supervisors, Kelsey Hegarty, the CAS is a widely used multi-dimensional measure of abusive behaviours by a partner (MacMillan et al., 2009). It has been independently assessed at the "criterion standard" because of its "comprehensiveness and strong psychometric properties" (MacMillan et al., 2006, p. 532; Wathen et al., 2008). The instrument has four subscales with Cronbach's alphas for each of >.85. (Hegarty et al., 2005; MacMillan et al., 2006; Wathen et al., 2008). A strength of the CAS is its ability to measure severity and abuse type (Hegarty et al., 2005). The CAS has been used in general practice, antenatal clinics, emergency departments, drug and alcohol clinics and general community samples. It has also been published in the *Centers for Disease Control and Prevention Compendium of International Intimate Partner Violence Measures* (Thompson et al., 2006). Despite the many strengths of the CAS, some of its characteristics have been critiqued, including the use of cut-off scores rather than a continuum, the wording of some items and the frequency options (Ford-Gilboe et al., 2016).

The CAS was chosen for *The WAV Project* survey after consideration of other DFV measures, including the WHO MCS and the CTS2 (García-Moreno et al., 2005; Hegarty et al., 2005; Straus et al., 1996; Swahnberg & Wijma, 2003; Wathen et al., 2008). It was evaluated as the superior measure, especially in the context of several significant shortcomings with other measures, including known misdetection problems (Brown et al., 1996; McFarlane et al., 1992), the absence of emotional abuse items (García-Moreno et al., 2005; Straus et al., 1996) and the lack of a 12-month prevalence measurement (Brown et al., 1996; García-Moreno et al., 2005; McFarlane et al., 1992; Swahnberg & Wijma, 2003). Additional issues affecting context (Straus et al., 1996), abuse frequency and the requirement for an English-language measure (Swahnberg & Wijma, 2003) provided the basis upon which other questionnaires were omitted.

The original CAS, developed in 1995, contained 74-items and was validated on a convenience sample of nurses (*n*=427, 33% response rate) (Hegarty et al., 1999). Further validation with general practice patients (*n*=1,896) and emergency department patients (*n*=345) resulted in the current 30-item version (Figure 8) (Hegarty et al., 2005). The CAS is a behavioural, rather than subjective, measure of abusive acts (Leung et al., 2019). The CAS enquires about specific acts of abuse, for example: '*In the last 12-months, did your partner or ex-partner push, grab or shove you?*' (Hegarty et al., 2005). The CAS was developed as a 12-month prevalence tool, asking about frequency of abusive behaviours during the previous year using six time-points: '*Never*', '*Only once*', '*Several times*', '*Once a month*', '*Once a week*' and '*Daily*'. Using cut-off scores, the CAS groups survivor participants into one of four abuse categories: 'Severe Combined Abuse', 'Physical Abuse combined with Emotional Abuse and Harassment', 'Physical Abuse Alone', and 'Emotional Abuse and Harassment' (Hegarty et al., 2005) (pages 252-254).

Severe Combined Abuse (8 items) Raped me Took my wallet and left me stranded Used a knife or gun or other weapon Tried to rape me Kept me from medical care Locked me in the bedroom Refused to let me work outside the home Put foreign objects in my vagina/anus	**Emotional Abuse (11 items)** Told me that I wasn't good enough Told me that I was stupid Did not want me to socialise with my female friends Told me that I was crazy Became upset if dinner/housework wasn't done when they thought it should be Blamed me for causing their violent behaviour Tried to turn my family, friends and children against me Told me that no one else would ever want me Told me that I was ugly Tried to keep me from seeing or talking to my family Tried to convince my family, friends and children that I was crazy
Physical Abuse (7 items) Pushed, grabbed or shoved me Hit or tried to hit me with something Shook me Slapped me Threw me Kicked me, bit me or hit with a fist Beat me up	**Harassment (4 items)** Harassed me over the telephone Followed me Hung around outside my house Harassed me at work

Figure 8. The four dimensions & 30 individual acts of abuse in the CAS
(Hegarty 2013; Hegarty et al., 2005)

Extending the CAS to become an adult lifetime measure

To determine exposure to abusive behaviour’s by a partner or ex-partner during a period longer than the last 12-months, the CAS timeframe was extended by asking the question: *Did this behaviour*: ‘*Happen more than 12-months ago*? *Yes/no* (Appendix B, pages 253-254). Participants were thus asked to consider two time periods for each CAS item: (1) frequency of abusive behaviour within the last 12-months, and (2) whether the abusive behaviour had happened longer than 12-months ago, since the age of 16 years. At the time of developing this survey, we could not find a previous research precedent extending the CAS in this way.

Scoring the CAS: 12-month prevalence

The 12-month CAS was scored by summing frequencies without weighting any of the 30 items (Hegarty & Valpied, 2013). Higher scores indicated greater severity of abuse. Each of the individual CAS items were given a score between 0-5 (*Never*=0, *Only once*=1, *Several times*=2, *Once/month*=3, *Once/week*=4, *Daily*=5). There were different possible scores for each of the four subscales (refer back to Figure 8, page 93, for items):

- Severe Combined Abuse (SCA) (8 items, possible score 0-40),
- Physical Abuse (7 items, possible score 0-35),
- Emotional Abuse (11 items, possible score 0-55),
- Harassment (4 items, possible score 0-20).

A total score was obtained by adding scores for all the items in the scale (30 items, each scored 0-5, allowing a possible total score of 0-150) or the total scores for each subscale. Standard cut off scores were used (Severe Combined Abuse=1, Physical Abuse=1, Emotional Abuse=3, Harassment=2) (Hegarty & Valpied, 2013). The final step in the scoring process involved categorising the abuse experienced by each participant. There were up to 15 different abuse type combinations (e.g. SCA + Physical; SCA + Emotional; and so on) that the CAS reduces to four major categories of violence experienced by women (Figure 9). In the categorisation process, SCA (severe physical, emotional and sexual violence) takes precedence over other dimensions of abuse, so that if a participant had experienced SCA and another category of abuse, they are categorised as having experienced SCA (Category 1). Category 2 is Physical Abuse in combination with

Emotional Abuse and/or Harassment. The third category, Physical Abuse Alone, includes participants with experiences of one or more episodes of physical abuse, not in combination with any other form of abuse. The final category (4) incorporates participants who have experienced Emotional Abuse and/or Harassment and no other forms of abuse.

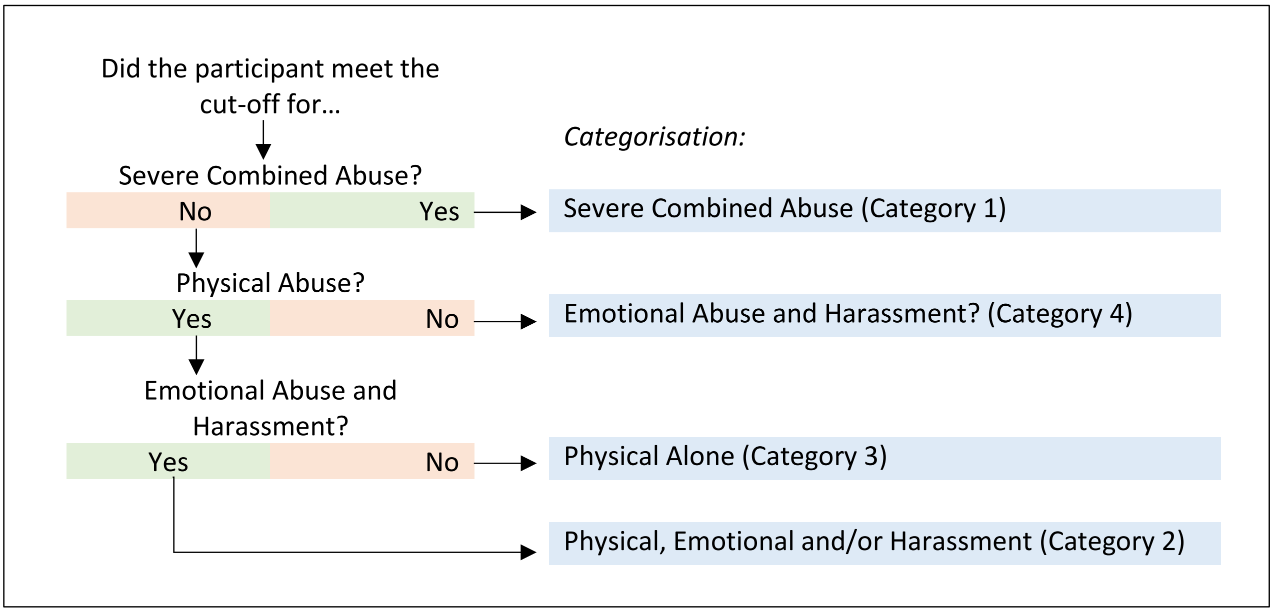

Figure 9. Decision tree for CAS 12-month & adult lifetime abuse categorisation

Scoring the CAS: Lifetime prevalence

Exposure to adult lifetime IPV (since the age of 16 years) was scored using the extended CAS, similar to the 12-month measure, except that each item was given a score of 0 or 1 denoting whether it happened more than 12-months ago (0=Did not tick box | 1=*Happened more that 12-months ago*). The same standard 12-month cut-off scores were applied to the four lifetime IPV subscales, so that the possible scores for each was:

- Severe Combined Abuse (SCA) (8 items, possible score 0-8),
- Physical Abuse (7 items, possible score 0-7),
- Emotional Abuse (11 items, possible score 0-11),
- Harassment (4 items, possible score 0-4).

A total lifetime IPV score was obtained by adding scores for all the items in the scale (30 items, each scored 0-1, allowing a possible total score of 0-30) or the total scores for each subscale. The next step was to add participants who had experienced IPV during the last 12-months so that they were captured in the lifetime IPV abuse variables. Participants who had experienced IPV in the last 12-months were given a score of 1. The final categorisation step followed the 12-month measure with SCA again taking precedence (Figure 9, page 95). For example, if a participant had experienced SCA (Category 1) longer than 12-months ago, and Emotional Abuse and Harassment (Category 4) in the last 12-months, they were categorised in the lifetime IPV prevalence as having experienced lifetime SCA but in the 12-month data they were categorised as having experienced 12-month Emotional Abuse and Harassment.

Lifetime family violence

Moving from IPV now, to abuse by non-intimate family members, extensive consideration was given to validated tools that assess family violence, child abuse and childhood witnessing of parental violence. However, most commonly used tools are lengthy (i.e. the 11-item Child Maltreatment History Self-Report) (MacMillan et al., 1997). Violence and abuse in the family of origin was not the main focus of this study, so the addition of an extensive multidimensional scale was considered an unjustifiably intrusive barrier to survey participation. As well as being time-consuming and potentially burdensome, longer questionnaires and those that are sensitive reduce the odds of response (Edwards et al., 2010).

In the absence of a validated measure, family violence (FV) was defined as encompassing violence and abuse directed at a participant by a family member at any time during the life course, as well as the witnessing of violence between parents during childhood. Based on a review of the literature, two questions to detect FV were developed; *"Have you ever experienced violence or abuse from a family member? (e.g. someone who is not your partner, like a parent, uncle, in-law, sibling) Yes/No"*; and, *"Growing up, was there ever violence or abuse in your home between your parents? Yes/No"* (page 255). Family violence was scored as 0, 1, or 2, with a score other than 0 indicating exposure.

Domestic & family violence

Exposure to DFV was inclusive of 12-month and lifetime IPV and/or lifetime violence by a family member. This variable was coded as 0/1. A participant was given a score of 1 if they had experienced one or more of the following:

- Lifetime fear of partner ≥1 (3 items, possible score 0-3),
- 12-month IPV score ≥3 (30 CAS items, possible score 0-150),
- Lifetime SCA (CAS Category 1) ≥1 (8 items, score 0-8),
- Lifetime Physical Abuse in combination with Emotional Abuse (CAS Category 2) ≥1 (7 items, score 0-7),
- Lifetime IPV score ≥7, (30 lifetime CAS items, possible score 0-30)
- Lifetime physical, emotional and sexual abuse by a family member = 1 (1 item, score 0/1),
- Witness of parental abuse as a child = 1 (1 item, score 0/1).

'Other' interpersonal violence

The focus of *The WAV Project* survey was IPV and FV. However, to capture the experience of interpersonal abuse or violence occurring outside intimate and family relationships, including the occupational setting (i.e. patients, colleagues, neighbours), participants were asked: *"Have you ever experienced violence or abuse from somebody other than a partner or family member? Yes/No. If yes, please describe"* (page 255). This question was developed with expert advice and upon review of the literature. Descriptions were categorised according to relationship with the perpetrator, the nature of abuse, the age when the abuse occurred and the number of different abuse occurrences/types. 'Other' interpersonal violence was scored as 0 or 1, with 1 indicating exposure.

DFV Training

Participants were asked to estimate the number of DFV training hours they had received during their undergraduate education or professional employment. The definition of DFV training was specific education about IPV, DFV or sexual assault. Ordinal categories encompassed: '0 hours', 'less than 4 hours', '4-8 hours', 'more than 8 hours' (page 245). Categories were scored 1 to 4 respectively. For analysis, this variable was made binary;

0 indicated less than 8 hours (less than 1 day) of accumulated training and 1 indicated 8+ hours (1 or more day/s).

3.10.2 Outcome variables

The outcome variables for this thesis were training (also a predictor variable, see above), DFV attitudes, comfort to discuss DFV and sexual assault, DFV enquiry, identification and interventions with survivor patients.

Attitudes

To investigate attitudes about DFV, a modified version of the Physician REadiness to Manage Intimate partner violence Survey (PREMIS) *Opinions* subscales was used (Short, Alpert, et al., 2006). The PREMIS is a validated tool designed to assess preparedness by health professionals to work with DFV (Connor, Nouer, Mackey, Tipton, & Lloyd, 2011). Its psychometric properties have been validated with physicians, nurses and social workers (Connor et al., 2011, p. 1014). Developed in the USA, validation studies have indicated Australian suitability: PREMIS has been used with general practitioners (Hegarty et al., 2010), midwives (Baird, Saito, Eustace, & Creedy, 2015) and paramedics (Connor et al., 2011; McAndrew, Pierre, & Kojanis, 2014; Sawyer, Coles, Williams, Lucas, & Williams, 2017; Sawyer, Williams, Rotheram, & Williams, 2018). To minimise response bias, reverse scoring applies to *Opinions* subscales where there is intentional negative wording (Short, Alpert, et al., 2006).

The WAV Project survey incorporated two of eight PREMIS *Opinions* subscales; '*Victim understanding*' (attitudes about survivors) and '*Workplace issues*' (attitudes about the role of the workplace) (pages 246-247) (Short, Alpert, et al., 2006). These subscales were selected because they were the most relevant to the study's research questions. Further, the language of these two subscales did not require significant modification for an Australian health and legal context, while other subscales would have (Connor et al., 2011). PREMIS subscales are scored individually and there is precedence for using them separately (Baird et al., 2015). PREMIS items are scored via a seven-point Likert-type scale, ranging from 'strongly disagree' (1), to 'strongly agree' (7), and the mean is used (Short, Alpert, et al., 2006). Two item examples are: *If a woman does not acknowledge* *the violence, there is very little I can do to help* (‘Victim Understanding’ subscale item), and, *I can make appropriate referrals for women to VAW services within the community* (‘Workplace’ subscale item). Slight modifications were required to make sure that terminology, concepts and language were suitable for an Australian health professional audience (Baird et al., 2015; Hegarty et al., 2010). For example, the PREMIS term “*health care provider*” was changed to “*health professional”* (Short, Alpert, et al., 2006). All language changes were made following a panel discussion about Australian parlance and alternatives. PREMIS was selected for use in this study because it had shown a high level of consistency and is the only measure of its kind (Connor et al., 2011; Short, Alpert, et al., 2006). However, in the years since data for this PhD was collected, a study with 260 Australian paramedic students found that the measure failed to emulate the robust psychometric properties it had shown previously, which was attributed to the instrument’s age, international context in which it was set and its initial validation with mostly medical professionals (Sawyer, Coles, Williams, & Williams, 2019; Sawyer et al., 2018).

Two additional attitude items brought the survey’s total to 14. One item was from the PREMIS ‘Staff Preparation’ *Opinions* subscale (*I do not have sufficient training to assist individuals in addressing situations of DFV*), and the remaining was created for the survey (*Asking about and responding to DFV is not part of my role or scope of practice at* [Hospital name]). Both were included because they were of specific interest to the recruiting hospital. However, these additional items were not scored with the two PREMIS subscales above or included in the clinical care practice variables, rather they were reported standalone.

Comfort to discuss DFV

Following a positive response to a screening question about clinical practice in the last six months, four items about comfort to discuss DFV were adapted from a previous Australian hospital study: ‘*weave’* (Hegarty et al., 2010). The question asked: *Thinking about the care and support you have provided women in the last 6-months, how comfortable did you feel asking about the following? Current/past domestic violence, current/past sexual assault* (page 248). Participants were asked to select one out of five points on a Likert-type scale ranking from ‘very uncomfortable’ (1), to ‘very comfortable’ (4), including ‘never asked’ (5).

DFV enquiry & post-disclosure interventions

Self-reported clinical care of survivor patients was measured via 12-items and also adapted from *‘weave’* (Hegarty et al., 2010). Items included DFV patient enquiry and interventions following a patient disclosure of DFV (page 250). Interventions were: risk assessment, safety planning, DFV documentation, use of DFV Clinical Practice Guideline and clinical consultation about DFV. The items were based on practice knowledge of the hospital environment and relevant initiatives to increase the confidence and capacity of staff to identify and intervene with survivor patients. Participants were asked to rate the frequency with which they had performed different aspects of practice during the previous six-months using a 5-point Likert-type scale ranging from ‘never’ (1) to ‘quite frequently’ (5).

A bespoke 8-item measure of survivor patient referrals to an internal hospital department (i.e. social work and mental health) and external specialist DFV service was scored via a 5-point Likert-type scale ranging from 'never' (1) to 'quite frequently' (5) (page 250).

To assess the impact of hospital signage, participants were asked if they had seen DFV posters, staff badges and pamphlets aimed at patients (yes/no). These items were created for *The WAV Project* survey based on the research site’s specific environment and interest (page 251).

To gauge health professionals' emotional responses to DFV enquiry of patients and clinical care following a patient disclosure, 4-items were created: *I have wanted to avoid raising the issue of VAW* [DFV] *with my patients/clients*; *I have found it upsetting to talk about the issue of VAW* [DFV] *with my patients/clients*; *I have been very aware of the issue of VAW* [DFV] *with my patients/clients*, and *I have tried to go the extra mile to respond to the issue of VAW* [DFV] *with my patients/clients* (page 256). Scoring occurred via a 6-point Likert-type scale ranging from 'strongly disagree' (1), to 'strongly agree' (5), inclusive of an *‘N/A – not in clinical practice’* option.

Demographics

Demographic questions included sex (female/male); age (<30, 30-39, 40-49, 50-59, 60+ years); professional background (midwifery, nursing, medicine, allied health, medical support, other), clinical area of work (maternity, neonatal services, gynaecology, women's health, other); length of employment at the hospital (<1, 1-2, 3-4, 5-9, 10-19, 20-29, 30+ years); years of clinical experience (<1, 1-2, 3-4, 5-9, 10-19, 20-29, 30+ years) and responsibility for supervision of staff (yes/no) (page 259). These questions purposely reflected annual hospital demographic data so that the representativeness of the sample could be gauged. Items also aligned with publicly available Australian health professional data for comparison (Australian Institute of Health and Welfare, 2013a, 2013b, 2014).

3.10.3 Confounding variables

Adjustment for potentially confounding variables was made *a priori* based on the literature and included: age (40+ years) (Bracken et al., 2010; Dickson & Tutty, 1996), allied health professional background (Dickson & Tutty, 1996; Rodriguez et al., 1999), DFV training (1+ days) (Gutmanis et al., 2007; Rodriguez et al., 1999; Stenson & Heimer, 2008) and years of clinical experience (10+ years) (Dickson & Tutty, 1996; Leung et al., 2019; Stenson & Heimer, 2008)}. The rationale for including these variables does not require extensive explanation, suffice to say that the literature suggests that hours of training, maturity and years of clinical experience all positively effect practice (Bracken et al., 2010; Dickson & Tutty, 1996; Gutmanis et al., 2007; Leung et al., 2019; Rodriguez et al., 1999; Stenson & Heimer, 2008). Further, adjustment for allied health professional background was made because the most common group of allied health professionals at the hospital were social workers, who could be presumed to have had more DFV training and clinical experience than other health professionals.

3.10.4 Other variables

The impact of DFV at work

The survey included 11-items about the impact of DFV on employment. These items were based on the previously mentioned Australian survey of 3,611 union members about their experiences of DFV (McFerran, 2011). Items included, *Took unpaid time off work* and, *Was stalked/harassed while at work by a partner or ex-partner* (see the survey on page 256 for a full list). Participants could select multiple responses to reflect their experience.

DFV workplace support

Created for *The WAV Project* survey, participants were asked about the perceived helpfulness of different types of workplace support for staff affected by DFV: specific DFV leave (paid and unpaid), DFV training for hospital managers and Employee Assistance Program counsellors (page 257). These supports were both theoretical and aspirational; at the time of the survey, DFV leave had been introduced into some Australian workplaces, but not the recruiting hospital. Managers at the hospital were not offered training about survivor staff, nor did the Employee Assistance Program screen for DFV at intake, rendering it unable to assign counsellors based on DFV expertise or clinical experience unless DFV was disclosed by a service user at intake (personal communication, T. Stewart and E. Gomo, 1 May, 2014). Items were scored via a Likert-type scale, ranging from ‘very unhelpful’ (1), to ‘very helpful’ (5).

Open-ended questions

Participants were asked two open-ended questions to answer research question three of this thesis and these will be detailed in Phase Two of the method (see page 106).

3.11 SURVEY ANALYSIS

This section describes the statistical methods used to analyse the quantitative data collected through the survey. Before embarking on analysis, a detailed plan was developed with the assistance of supervisors, and a statistician who was also a STATA software expert (StataCorp, 2015). Analysis methods for Phase One are presented in this section, with the most common - logistic regression - reviewed in some detail.

3.11.1 Data preparation, cleaning & coding

The combined data file of the electronic and paper survey data was exported from Survey Monkey (Survey Monkey Inc, 2018) to Windows Excel (Microsoft Corporation, 2017), from which it was imported into STATA (Version 13) (StataCorp, 2015). All cleaning, coding and analysis was undertaken in STATA (StataCorp, 2015). Six logical checks were applied to test the accuracy of the data (Appendix M). Some logical checks were to ensure that paper data entry followed the requested skip directions and that Survey Monkey skip logic performed as expected. For example, if a participant selected a history of ‘0’ hours of professional DFV training, they should have skipped the proceeding ‘type of training’ question. Other logical checks were to make sure all data was plausible. For example, if a participant identified that they had 30-plus years of clinical experience, it would follow that they must be 50-plus years old. Minimal logical check breaches were identified. All changes made to rectify erroneous data were in consultation with PhD supervisors. Some free-text responses were recoded, for example, *'other'* interpersonal violence was coded by relationship to perpetrator and so on.

3.11.2 Missing Data

Participants will frequently not answer all questions in survey research, resulting in missing data. The goal of research is to make inferences that can be applied to the population beyond the sample studied, and incomplete data hampers this. Different factors contribute to why data is missed, understanding what data is missing, underlying patterns, and the possible reasons matter, as can finding an effective statistical remedy (Gow, 2016). Our survey contained sensitive questions, which are known to increase the risk of missing data (Gow, 2016). For the 12-month and adult lifetime IPV measure, the CAS missing data guidelines were followed (Hegarty & Valpied, 2013). These specified that if less than 30% of the 30 items were missed, data substitution could be appropriate for that subscale. In that case, zero substitution was employed, whereby missing responses were substituted with zero, resulting in a more conservative estimate of the number of women meeting the cut-off scores for each subscale (Hegarty & Valpied, 2013). If more than 30% of the items were missed, data substitution was not used and the full subscale was considered missing (Hegarty & Valpied, 2013). During univariate analysis, the proportion of missing data for each response was assessed. Across the survey, less than five per cent of the data was missing. In response to this, the ‘*95% rule*’ was applied, the principle of which is that different treatments of missing values will have little or no impact on the substantive interpretations since 95% of the observations are still available for use (Gow, 2016).

3.11.3 Analyses

Once the data was cleaned and coded, the analysis phase began by gaining familiarity via extensive univariate analysis. Minimum and maximum values were checked for each variable of interest, the mean, median and mode as appropriate, and the range and standard deviation for the spread of scores (Osborne, 2010) (see Appendix N for example). It was during this checking phase that the extent of missing values for each variable was examined. Univariate analysis using frequencies and percentages described sample demographics, employment characteristics and exposure to IPV, DFV and 'other' interpersonal violence. Clinical interventions to identify and respond to DFV were summarised using frequencies and percentages for categorical data and means and standard deviations for ordinal data. Independent t-tests and Chi-Square tests of comparison compared mean scores. Linear regression compared differences in mean scores for attitudes about survivors and the role of health services. Cross-tabulations examined the association between specific participant characteristics, i.e. sex, age, professional background, area of practice and exposure to DFV. Descriptive analysis was usually performed using the categorical or binary form of a variable.

Logistic regression

Logistic regression was the most performed method of analysis, used for: comfort asking about DFV, clinical interventions and some demographic variables. Logistic regression analysis models the association between binary outcomes and exposure variables through odds ratios (OR) (Kirkwood & Sterne, 2003). Associations can be indicated but not the direction or causality between two characteristics (Kirkwood & Sterne, 2003). Logistic regression allows flexibility to examine multiple exposure variables while exercising control over confounding variables. Logistic regression models were used to test the characteristics of: 1) participants who self-reported DFV clinical care of survivor patients in the last six months compared to participants who did not (see Appendix O for full list of how variables were binarised); 2) participants who had experienced lifetime DFV (i.e. scored for inclusion in the 12-month or adult lifetime CAS or had a history of family violence including childhood witnessing) compared to those who had not; moderated by the potential effect of, 3) participants aged 40 years or older; participants with an allied health professional background; participants with one or more days cumulative DFV professional training; and participants with ten or more years of clinical experience.

ORs indicate the likelihood that a participant will be in a particular group, while the size of an effect is calculated by the confidence interval (CI) (Kirkwood & Sterne, 2003). An OR of 1.0 designates no effect, whereas >1 indicates an effect (Haddock, Rindskopf, & Shadish, 1998). The effect of being in one group or the other was determined through examination of the CI and the *p*-value in combination. CIs indicate the precision surrounding the OR point estimate, with a wide CI indicating low precision and a narrow CI, high precision. Underpinning the 95% CI is the principle that if data collection and analysis were performed repeatedly, the range of the interval would include the correct value 95% of the time (Kirkwood & Sterne, 2003). *P*-values indicate how far chance alone explains observed differences in a sample, acting as a sort of snapshot of the strength of the evidence (Wood, Freemantle, King, & Nazareth, 2014). *P*-values are regarded with caution however, especially when reported in the absence of 95% CIs (Harrington et al., 2019). The size of a sample influences *p*-values and set threshold values are arbitrary. For example, the commonly reported threshold of 0.05 implies that by chance alone, one in 20 tests will produce a *p*-value less than 0.05 when a meaningful difference does not, in fact, exist (Kirkwood & Sterne, 2003). In this light, significant *p*-values (<0.05) were interpreted alongside ORs and CIs to assess whether a meaningful association was plausible.

Summary

Having described the design of Phase One of the study including the rationale for the cross-sectional survey, the participants, procedure, survey development, two-phased recruitment and analysis, the quantitative methods utilised in this study are now concluded. The focus of this Chapter now moves to the qualitative methods used in Phase Two of this study. First, the rationale for the use of interviews is asserted, followed by a review of the participants, procedure, design and qualitative analysis for interviews and open-ended survey questions with survivors. This Chapter ends with an exploration of the ethics of this project.

3.12 PHASE TWO: INTERVIEWS & QUALITATIVE METHODS

Qualitative methods were applied to answer research questions three and four in Phase Two of this project: *What support needs do survivor health professionals have of their hospital workplace?* and *What are the views of key stakeholders about the role of the workplace in responding to staff survivors?* The support needs and experiences of survivors were sought via their responses to open-ended survey questions, while the views of key stakeholders were explored within semi-structured interviews. This section of the method will give an account of the process for collecting qualitative data and how that data was interpreted.

Open-ended survey questions

Research question three was answered via two open-ended questions put to all health professional participants in *The WAV Project* survey (page 258). These questions were about support that participants would find useful regarding their experience and their role working with survivor patients:

> *Are there any additional supports you would like to see in place at the hospital for staff who are dealing with personal experiences of DFV or sexual assault?*
>
> and,
>
> *What things could the hospital do to support you in your work dealing with patients who have experienced DFV or sexual assault?*

The purpose of these questions was to try to understand participants' beliefs, ideas and experiences. The rationale for selecting this method was to extend the quantitative findings, by moving beyond mere description of the problem (prevalence) and its clinical impact, to an exploration of the "so what" role hospital workplaces can and should play in responding supportively to survivor staff. Asking open-ended questions is a valid method of collecting qualitative data, one that can evoke a broader range of views than other qualitative methods, although the data may not be as rich as that elicited within interviews for example (Braun & Clark, 2013). However, this project raised confidentiality issues that would have been almost impossible to navigate if I had asked survivor employees to consider participating in an in-depth interview with me (their colleague) about their experience of being a survivor in our shared workplace. It would not have been ethical for me to interview my colleagues about such personal, sensitive and potentially painful experiences. However, issues of confidentiality and being an insider were not the only reasons for choosing the open-ended question method. We also wanted to hear from participants with a range of experiences and perspectives, as well as working within the time and resource constraints of this project. For all of these reasons, open-ended survey questions were selected as the best way to incorporate survivor voices. All participants were presented with the open-ended questions in their survey, but it was the 93 survivor health professional participants who answered one or both of the questions, whose data was analysed for this project and is presented in Results Chapter 6.

3.12.1 Rationale for the interview design

Research question four was answered via semi-structured individual and group interviews with key stakeholders about the role of the hospital and surrounding support system in responding to staff who had experienced DFV. Driving method preference was the exploratory nature of this research question. The lack of prior research about the role of the healthcare workplace in responding to survivor employees excluded other methods that might limit the richness of the data. Interviews seek to understand participants' subjective meaning, actions and context and this method is consistent with a feminist paradigm and analysis (Campbell & Schram, 1995). The choice of research questions, interview questions and data analysis strove to explore participants' experiences through privileging their ideas and perspectives (Kuzel, 1992).

3.13 INTERVIEW PARTICIPANTS

Sampling in qualitative research focuses on relatively small samples, which are chosen purposefully (Farrugia, 2019; Gibbs et al., 2007; Kuzel, 1992; Patten, Newhart, Patten, & Newhart, 2018; Patton, 2002). This study was interested in exploring the views of women and men in their role as a leader within the hospital sector with responsibility for administering the hospital workplace, supervising clinical staff or supporting staff wellbeing. All hospital staff employed at the level of "manager", "director" or "executive" were eligible to participate in an individual or group interview. The questions put to interviewees were about the perspectives they held in their professional role. Interview participation was also invited from individuals in leadership positions at a leading health professional Union and the hospital Employee Assistance Program. Recruitment was based on purposive sampling to explore a wide range of views. In total, 18 key stakeholders participated in an interview between April and June 2014: eleven took part individually, and seven took part in one of two group interviews for convenience. Group interviews were offered to employees in the same team, e.g. employees in HR and the Employee Assistance Program.

3.14 INTERVIEW PROCEDURE

Via email, twenty individuals identified as key stakeholders were invited to take part in an interview with me during their work time (Appendix P). All but two agreed to participate. At the beginning of the interview, the interviewee was invited to read a Plain Language Statement (Appendix Q) and sign a consent form (Appendix R). All key stakeholder participants consented to their interview being audio recorded for later transcribing. Key stakeholders were extended the choice to be sent a copy of their interview transcription. Interviews lasted between thirty minutes to an hour in length. Audio recordings of interviews were transcribed verbatim by a private transcription service, using financial assistance conferred by both supervisors. A selection of transcripts was checked to ensure accuracy and few minor errors were identified. Written transcriptions were then imported into NVivo (Version 11) (QSR International Pty Ltd, 2018).

3.15 INTERVIEW DESIGN

Interviews were semi-structured, and open-ended questions with interviewees explored what the role of a hospital workplace was or should be in responding to staff survivors. This included what the hospital was doing well/could improve on and the components of an effective response using a case example prompt. Preliminary findings from *The WAV Project* survey about the prevalence of DFV in a sample of health professional women indicated that DFV was common and represented a starting point for the discussion. The survey had closed approximately four months before the onset of interviews. The interview questions were not prescriptive, and as the interviewer I followed up on things said or asked participants to expand on concepts they introduced. Within the interview schedule, the term *staff participants* refers to health professionals who completed the survey. The term '*we*' was used in the interview schedule as I was both the interviewer and a staff member. I did not know any of the participants well at the time of the interview, nor was I employed in the same department or had ever reported to them. The interview schedule with key stakeholders was as follows:

1. *Staff participants told us that intimate partner violence and sexual assault was common in their personal lives. What do you think the role of a workplace such as* [hospital name] *should be in terms of responding to violence in the lives of staff?*

2. *Staff participants also told us that violence does affect their work ... What do you think might be useful for this workplace to think about in order to better support staff experiencing violence and abuse?*

3. *What do you think this workplace is doing well now that we should hang on to in terms of how the hospital responds to DFV (i.e. thinking of staff and patients)?*

4. *What could we be doing better? What do you think we should develop and/or prioritise in the area of DFV into the future?*

5. *If a staff member has come to work and disclosed DFV, or appears to be recovering from a recent DFV incident, what do you think the role of a manager/senior staff member should be towards that staff member?*

6. *Are there any final comments that you would like to make?*

At the earliest juncture post-interview completion, I reflected on my experience of the recent interview. These notes were for my own use; they assisted with processing my thoughts about the interview and were useful to refer to during the analysis phase.

3.16 QUALITATIVE ANALYSIS

Qualitative data was derived from both the interviews with key stakeholders and the open-ended responses offered by survivor staff. Analysis of both types of data will be discussed together here. Analysis followed a ‘thematic’ approach, the phases of which are specified by Braun and Clarke (2006) (Table 10).

Table 10. Phases of thematic analysis

Thematic analysis phase	Description of the process
1. Become familiar with the data	Transcribe, read, re-read and note initial ideas
2. Generate initial codes	Code interesting features in the data systematically across the dataset, collating data to each code
3. Search for themes	Collate codes into potential themes, gathering all of the data relevant to a potential theme
4. Review the themes	Check if each theme works in relation to coded extracts (Level 1), and the entire data set (Level 2), creating a thematic ‘map’
5. Define and name themes	Refine the specifics of each theme and the overall story through ongoing analysis. Develop clear definitions and names for each theme
6. Write the report	Final opportunity for analysis. Select compelling data extracts. Relate back to analysis of the research questions and produce a scholarly report

Notes

[1] This table has been adapted from Braun and Clarke (2006, p. 87)

Within this application of thematic analysis, my subjectivity was interpreted as a distinct resource when combined with reflectivity and contemplation of the broader context of meaning. Subjectivity was not viewed as a challenging characteristic to be managed (Clarke & Braun, 2018). I critically reflected on my role bearing witness too, and in this research, juggling the hats of a clinician, hospital employee and emerging researcher. As part of examining my role, I met with my PhD supervisors to review and reflect (Critical Appraisal Skills Programme, 2018). In my employment position as a sexual assault counsellor at that time, I was also undertaking clinical supervision external to my workplace and was able to use this resource to contemplate the interviews further. As Clarke and Braun (2018) assert, the final themes did not emerge, fully formed, out of the data. Rather, they were actively created from the research and with my supervisors (Clarke & Braun, 2018).

3.16.1 Open-ended survey question analysis

Clarke and Braun (2014) assert that thematic analysis can be used for a range of qualitative data, including textual survey data. However, the process and outcomes are likely to be different for interview data. Accordingly, I found that the richness of the interview data was not consistently present in the survey data. Responses to the open-ended questions by survivor health professionals ranged from a short sentence to several paragraphs in length, and in-depth analysis was not always possible (Kulkarni and Ross, 2016, Braun and Clark, 2013). Nevertheless, my aim was always to avoid the trap of mere description and summary (Clarke & Braun, 2018). I tried to capture the meaning of the data, however brief, and tell its story. I began by becoming familiar with the data. Every comment was read and re-read, and I compiled a list of initial codes for the survivor data. I did this without an *a priori* framework and by cognitively distancing myself from early ideas about questions of the data or frameworks for understanding (Thomas & Harden, 2008). After some weeks, this process was repeated. An inductive approach explored codes and synthesised those codes into themes; interpreting their meaning and implications. The same process started analysis of the key stakeholder interview data.

3.16.2 Interview data analysis

A more detailed analysis could occur with the interview data from the key stakeholders. Similar to the process for the survivor survey data, I read and re-read interview transcripts while listening to the interview audio. I read over my post interview reflections and developed a list of initial codes. At the same time, I kept a separate document of my reflections of engaging in this process of analysis. Open coding followed, the purpose of which was to generate concepts for both the health professional survey participants and key stakeholder interviewees. Upon conclusion of the separate analysis of the two sets of data, the themes and subthemes were brought together to understand connections and distinctions between survivor staff and key stakeholder interviewees. Through this process, shared meanings between the survivor health professionals and key stakeholders were highlighted, and contrasted by disjuncture (Clarke & Braun, 2018). An iterative process with my supervisors ensued; themes were checked to understand their fit with the coded extracts and the entire data set and refined through a series of thematic maps (see Appendix S for the thematic map of final main themes). Keeping step with standard convention when representing prevalence in thematic analysis, a decision was made not to provide a quantifiable measure (i.e. an exact number) of the survivor health professionals or key stakeholder participants who contributed to a particular theme in the written results (Braun and Clarke, 2006). Rather, the proportion was indicated where it was deemed helpful for the reader. My supervisors and I agreed on the distinctions between each theme and reviewed the overall narrative of the analysis. Finally, we were all involved in the naming of each theme (Braun & Clarke, 2006).

This concludes presentation of the qualitative methods used in this study, their development procedures and analysis. The Chapter now pivots to the ethics of this research and the process of how each identified issue of concern was addressed.

3.17 ADDRESSING ETHICAL ISSUES

There are several challenges to conducting rigorous and ethical research on the topic of DFV. This final section of the Methods Chapter is a reflection about the ethical issues of this research. Throughout the study, the safety and wellbeing of participants was of foremost concern. The ethical issues that were carefully considered and planned for included: perpetrator awareness, participation choice and informed consent, participant distress, the possibility of increased disclosures and confidentiality (World Health Organization, 2007). Mitigating risks that could cause harm to participants was informed by best practice DFV research gained from training and years of clinical experience with survivors, as well as supervisors' networks with international researchers (Ellsberg & Heise, 2002; Testa et al., 2011; World Health Organization, 2007). By the time of this project, I had more than eight years professional social work and counselling experience talking with women and health professionals about DFV and sexual assault and both supervisors had decades of experience talking with survivors and leading safe and ethical DFV research.

Perpetrator awareness

The most significant consideration for this project was the safety of survivors which could be threatened if a perpetrator became aware of their partner's participation (Ellsberg & Heise, 2002). A dual approach was utilised to maximise the safety of prospective participants: we undertook measures to reduce the possibility of a perpetrator becoming aware of their partner's participation, and we made a decision to provide health professionals with advanced notice of the project so that they could determine their safety to participate. In addressing the first approach, measures to minimise the possibility of a perpetrator becoming aware of the project included all survey communication being sent to workplace password-protected email addresses. Since the electronic survey could only be accessed via a workplace email address, it was assumed that this would usually be accessed in a participant's workplace. To prioritise the safety of health professionals who were sent a physical survey, this was placed in a plain envelope and attached to the health professional's timesheet at a physical location in the workplace. Additionally, no phone calls were made to prospective or follow-up participants at any time. Regarding the second approach, potential participants were given information about the project topic and purpose so they could make informed decisions about whether, when and where it was safe to participate. This information was relayed via email, on the project poster, in team meetings and other presentations, and within the staff newsletter over many weeks before and during recruitment.

Participation choice & informed consent

It was anticipated that health professionals could possibly feel pressured or coerced to participate in the project since the PhD Candidate responsible for the study worked at their workplace, and since the CEO (acting) of the hospital endorsed the project. To minimise this risk, all project correspondence made clear that participation was entirely voluntary and confidential. Additionally, health professionals were advised that they could contact the researchers with questions about the project. Despite my employment at the same hospital as most of the key stakeholders, inviting them to participate in an interview with me was not anticipated to cause ethical concerns, since interview participants were neither asked about their trauma history or personal life. Additionally, all key stakeholders were in a position of leadership within the organisation, while I was not.

Participant distress

It was anticipated that participation in the project, or even preceding information about it, could conceivably remind health professionals of previous experiences of DFV violence, triggering distressing feelings (World Health Organization, 2007). Further, a secondary traumatic response based on the experiences of survivor family, friends or patients could be elicited (Gregory, Williamson, & Feder, 2017). To address these concerns, within both the Plain Language Statements (Appendices G, L, Q) and attached to the survey (Appendix B) was information about DFV-specific support services external to the workplace. Participants were advised that they could access debriefing - active listening, discussion of options, safety planning and facilitated referral if necessary, with a member of the project team. While support for distress was prepared for based on previous research experience, it was not expected (Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014).

In the end, the experience of this project was that neither information about the project, nor participation, appeared to visibly cause distress or prompt the need to talk in a way that the research site or the researchers were required to manage. No calls were made to the project phone for information or support, nor to the HR department of the hospital, even months after recruitment concluded. Managers reported that they were not aware of increased discussion about DFV by their staff, nor had disclosures been made to them. Data did not suggest that there had been an increase in the number of staff attending the confidential Employee Assistance Program. Of course, it is possible that participation in the project contributed to distress or an increased risk of violence that participants did not disclose, or that survivors accessed support prompted by their participation in the project informally within the organisation, or outside.

Increased disclosures

The potential for an increase in DFV disclosures at the recruiting hospital by survivor health professionals was recognised. The ideal response to that occurrence would be both sensitive and informed, provided by somebody who felt prepared. To this end, a concerted effort was made to train as many managers and HR staff as possible prior to recruitment to strengthen their capacity to respond sensitively to disclosures of DFV. I facilitated training about best practice response principles to as many managers as were interested - 22 in total representing ~46% of all relevant managers, and the entire HR department. It is worth noting that these were clinical managers and not the same individuals as participated in the key stakeholder interviews. Staff referral and ongoing support material was developed so that key people to whom a disclosure might be made could refer to it later (Appendix T). The hospital's Employee Assistance Program was contacted, advised of the recruitment period and the risk of a potential increase in staff disclosures. Several female managers disclosed their own lived experience of DFV in my meetings with them, perhaps the first indication of the commonality of DFV trauma for health professional women.

Confidentiality

To ensure the confidentiality of participants, all data presented in reports, publications and conference presentations arising from this project was aggregated and de-identified. To further this aim, a decision was made that the name of the hospital where the research took place would not be disclosed. Instead, the hospital is identified as an Australian tertiary maternity hospital in this thesis and in all presentations of the findings including publications. All guidelines about confidential storage of data have been adhered to, and in the future, records will be destroyed in such a way as to ensure complete destruction of information.

Ethics approval

Ethics approval for this research was granted by the recruiting hospital (ID: 12/34, (approval letter unable to be included in Appendix to maintain research site anonymity) and registered with the University of Melbourne (ID: 1339986, Appendix U).

3.18 CONCLUSION

In this Chapter, the methodology applied to investigate the prevalence of DFV in an Australian health professional population and associations with clinical practice in Phase

One were detailed. This was followed by an assay of the method used in Phase Two to explore the implications for the hospital workplace from the perspectives of both staff survivors and key stakeholders. The contribution of theories foundational to the project, including feminist theory and the ‘combined methodological approach’, were discussed. The health professional and key stakeholder participants, recruitment procedures, survey and interview design and quantitative and qualitative analyses were laid out, with the principle statistical technique, logistic regression, examined closely. This Chapter ended with consideration of the ethical implications of the project, including the primary focus that participants’ physical and emotional safety was not put at risk by the project. Discussion of the strengths and limitations of this project, including the Methods, are expounded in the Implications Chapter. In closing this Methodology Chapter, Part I of this thesis is now concluded.

In Part II of this thesis the results are presented. The findings of three studies appear as peer-reviewed journal articles.

Chapter 4: DFV prevalence study - “*It happens to clinicians too*”: An Australian prevalence study of intimate partner and family violence against health professionals;

Chapter 5: Clinical impacts study - *Is a clinician’s personal history of domestic violence associated with their clinical care of patients?* A cross-sectional study;

Chapter 6: Hospital workplace responses study - *Hospital responses to staff who have experienced domestic and family violence*: A qualitative study with survivor health professionals and hospital managers.

Part II

Results

4.

DFV prevalence study

"I have been physically threatened with "Cut my throat" and "I'll follow you to your car". I have been bitten; had a bedside table rammed into my back and been choked by patients... I have been called all sorts of things... I have been yelled at by partners… and I have been verbally abused and bullied by my colleagues…"

(Survivor health professional participant)

"…if we expect staff to have a heightened awareness of DFV so that they ask patients about it, then by default you'll identify staff who will reflect on those questions and realise they are, or have been, in the same position."

(Hospital manager participant)

4.1 OVERVIEW

Chapter Four presents the first of three manuscripts written during candidature. The findings in Chapter Four answer the research question: *What is the prevalence of DFV and other interpersonal violence in an Australian health professional population?* This prevalence study of Australian health professional women at a tertiary maternity hospital focused on the 12-month and lifetime incidence of IPV, lifetime prevalence of violence by a non-intimate family member and experience of abuse and violence by people outside the family. In this manuscript the background literature to the topic is presented, establishing the knowledge gap. Measures are reviewed as well as the study design and findings. The discussion explores the implications of DFV against health professional women. This manuscript was peer reviewed and published in *BMC Women's Health* in June 2018. As the lead author, I wrote 90% or more of this paper, with important contributions on all aspects of its content from my co-author supervisors. All authors read and approved the final manuscript prior to submission. There was not scope within the published manuscript to include all of the data and analysis relevant to the research question. Further analysis of demographic factors related to DFV prevalence, overlap in experiences of abuse, and issues to do with recall of abuse will sit as a final section to complete this Chapter.

A note about the language used across the three results manuscripts

While the language used to describe violence against women in the thesis is *domestic and family violence* (DFV), the language across the three results manuscripts differs. This is because each of the manuscripts went through a peer-review process at a different journal and the reviewers influenced the language used in each paper. In this manuscript, the terms IPV and FV are employed.

4.2 PUBLISHED RESULTS MANUSCRIPT (PAPER 1)

McLindon *et al. BMC Women's Health* (2018) 18:113
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BMC Women's Health

RESEARCH ARTICLE

Open Access

"It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals

Elizabeth McLindon[1,3*], Cathy Humphreys[2] and Kelsey Hegarty[1,3]

Abstract

Background: The purpose of this study was to measure the prevalence of intimate partner and family violence amongst a population of Australian female nurses, doctors and allied health professionals.

Methods: We conducted a descriptive, cross-sectional survey in a large Australian tertiary maternity hospital with 471 participating female health professionals (45.0% response rate). The primary outcome measures were 12 month and lifetime prevalence of intimate partner violence (Composite Abuse Scale) and family violence.

Results: In the last 12 months, one in ten (43, 11.5%) participants reported intimate partner violence: 4.2% (16) combined physical, emotional and/or sexual abuse; 6.7% (25) emotional abuse and/or harassment; 5.1% (22) were afraid of their partner; and 1.7% (7) had been raped by their partner. Since the age of sixteen, one third (125, 29.7%) of participants reported intimate partner violence: 18.3% (77) had experienced combined physical, emotional and/or sexual abuse; 8.1% (34) emotional abuse and/or harassment; 25.6% (111) had been afraid of their partner; and 12.1% (51) had been raped by their partner. Overall, 45.2% (212) of participants reported violence by a partner and/or family member during their lifetime, with 12.8% (60) reporting both.

Conclusion: Intimate partner and family violence may be common traumas in the lives of female health professionals, and this should be considered in health workplace policies and protocols, as health professionals are increasingly urged to work with patients who have experienced intimate partner and family violence. Implications include the need for workplace manager training, special leave provision, counselling services and other resources for staff.

Keywords: Intimate partner violence, Family violence, Violence against women, Sexual assault, Health professionals, Prevalence

Background

Violence against women, specifically intimate partner violence and family violence (hereafter referred to as 'intimate partner and family violence', is a serious and prevalent public health issue [1]. Intimate partner violence (IPV) is defined as "any behaviour that causes physical, psychological or sexual harm to those in that relationship" [2], and Family Violence (FV) is defined as harmful behaviour perpetrated by a non-intimate family member at any time in the life course, including the witnessing of violence between parents [3]. Throughout this paper, we use the terms: IPV when referring to violence by a partner, FV when referring to violence by a non-intimate family member, and intimate partner and family violence when referring to both violence by a partner and/or non-intimate family member. Global estimates of IPV are that it affects between 15 to 71% of ever-partnered women across their lifetime [4]. Australia's IPV prevalence is towards the lower end of that spectrum, with 25% of adult women in a national survey experiencing at least one incident of physical or sexual IPV during adulthood, 2.1% in the last 12 months [5]. The prevalence of physical or sexual violence before the age of fifteen is 16%, predominantly occurring within the family of origin,

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while 13% of Australian women were exposed to FV as children [6]. IPV contributes to a range of physical, sexual, psychological and reproductive health issues [7]. Survivors of IPV present to health care services more than other women [7], and during pregnancy there are increased risks for the unborn baby [8]. Thus, health professionals are increasingly recognised as having an essential role to play in identifying IPV survivor patients and providing a timely evidence-based response [9]. However, there are barriers to health professionals providing such interventions [10]. These include discomfort discussing the issue, lack of time and knowledge [10], and personal history of IPV [11].

While the majority of nurses and allied health professionals employed at public hospitals are women, little is known about the prevalence of IPV and FV against these health professionals [12, 13]. An extensive search of the academic literature (1987–2017) using three main search terms and synonyms - intimate partner violence, family violence, personal experience and health professional - identified fourteen quantitative studies into intimate partner and family violence against nurses and other health professional groups globally [12, 14–26]. None of these studies were Australian. The lifetime prevalence rate ranged between 3.7% (doctors in the United States) [17] and 97.7% (doctors and nurses in Pakistan) [18]. A large study conducted in a country with a comparable population prevalence rate to Australia is that by Bracken et al. (2010) in the United States [12], who surveyed 1981 nurses and found that the lifetime physical or sexual IPV prevalence rate was 25%. The strengths of this study included the large sample size and response rate (52%); however, this study did not cite the use of a validated scale and asked a small number of IPV questions. More recently, the Cavell Nurses' Trust surveyed 2254 British nurses about their health and well-being, including their exposure to IPV [26]. They found that, in the last 12 months, 12.2% of nurses had experienced non-physical abuse by a partner, while 3.1% had been physically abused, and these were substantially increased rates to that of the general community [26]. The limitations of the few studies on this issue include: a lack of rigor in the assessment of IPV [12, 14, 16, 17, 20, 22], low or unpublished response rates [20, 23, 26], small sample sizes [21, 23, 24], or publication ten or more years ago [15–17, 24, 25]. Another feature of these studies is their diversity: six of the studies were conducted in countries where a language other than English is the official language [15, 16, 18, 19, 21, 23], and in some countries prevalence studies were hard to generalise to the Australian context since the population prevalence was substantially higher than reported in the Australian community [18, 22, 23].

The primary objective of our study was to address a gap in the available evidence about exposure to 12 month and lifetime IPV and lifetime FV, against female health professionals in Australia. The secondary objectives were to investigate the prevalence of interpersonal violence perpetrated by people other than partners/family members (i.e. colleagues, neighbours, strangers) against health professionals, and to investigate whether age, professional background and/or years of experience were associated with a history of intimate partner and family violence.

Methods

We developed a cross-sectional survey about health professional's personal experiences of IPV, FV and other violence in the context of professional clinical care. Our survey included questions about demographics, work-related characteristics, exposure to IPV during the last 12 months and adult lifetime, lifetime FV and lifetime other violence. We defined IPV as physical, sexual and/or psychological violence, including the threat of such violence, occurring within an 'adult intimate relationship' (lasting longer than one month) with a partner/boyfriend/girlfriend/husband/wife, since the age of sixteen. We used the Composite Abuse Scale (CAS) to measure the prevalence of IPV; a 30-item well validated self-report measure of physical, sexual and emotionally abusive behaviours [27, 28]. Hegarty et al. (1999) developed the CAS using a sample of 427 Australian nurses (33% response rate) [27]. It measures IPV in the previous twelve months using a 6-point scale, and we adapted it further to measure adult lifetime IPV (since the age of sixteen). The CAS uses cut-off scores, which groups participants into four categories of IPV: 'Severe Combined Abuse' (severe physical, emotional and/or sexual violence), 'Physical Abuse combined with Emotional Abuse and/or Harassment', 'Physical Abuse' alone (not in combination with any other category of abuse), and 'Emotional Abuse and/or Harassment' alone (not in combination with any other category of abuse).

We defined FV as encompassing violence directed at a participant by a family member at any time during the life course and/or the witnessing of violence between parents during childhood. Based on a review of the literature, we developed two questions to measure FV; *"Have you ever experienced violence or abuse from a family member? (e.g. someone who is not your partner, like a parent, uncle, in-law, sibling) Yes/No"*; and, *"Growing up, was there ever violence or abuse in your home between your parents? Yes/No"*. While the focus of our study was IPV and FV, we also wanted to capture a participant's overall experience of interpersonal violence, so we asked one further question about incidents of lifetime violence perpetrated by someone not intimately known, i.e. a patient, colleague or neighbour: *"Have you ever experienced violence or abuse from* *somebody other than a partner or family member? Yes/No. If yes, please describe".*

The survey, conducted between 8 August and 31 December 2013, was anonymous and voluntary, and completion implied consent. The research was conducted at a single site – a large, tertiary maternity hospital in Australia. Piloting of the survey led to modifications of the wording. We recruited via two methods: (1) online (Survey Monkey) and (2) a paper-based survey to ensure that health professionals without access to a computer in a confidential setting had the opportunity to participate. A third-party recruiter employed by the hospital administered the survey. The online survey link and encouragement to participate by the Chief Executive Officer were distributed via email to all part-time/permanent clinical staff - nurse/midwives, doctors and allied health professionals. Staff were excluded if they were employed casually, or did not work in a clinical capacity (i.e. administration staff). Two reminder emails were sent, at two and three weeks post recruitment commencement. The third-party recruiter had a de-identified list of identification numbers for all potential participants to ensure that a participant did not submit a survey more than once. Reminder emails were targeted to those who had not yet participated. The third-party recruiter arranged for a paper survey and a reply-paid envelope to be delivered to the timesheet pigeonhole of the remaining eligible health professionals who had not yet participated. Coffee vouchers at the hospital café were offered to all staff as incentive and appreciation for considering participation and were not conditional on having completed the survey. Ethics approval was granted by both the recruiting hospital and the University of Melbourne Human Research and Ethics Committees (Ethics ID: 1339986).

Statistical analysis

Univariate analyses using frequencies and percentages were performed to describe the sample, including demographics, work-related characteristics and exposure to IPV, FV and other violence. Odds ratios, 95% confidence intervals (CI) and *P*-values were used to assess the likely size of the association between demographic variables and categories of abuse. Data were imported, cleaned, coded and analysed with STATA version 13.

Results

We sent the survey to 1047 female health professional staff, and 471 participated: 366 completed the survey electronically, while 105 returned a paper version, giving a response rate of 45.0%. The professional background of our sample included: 67.5% (317) nurse/midwives; 14.7% (69) doctors and 13.0% (61) allied health professionals (i.e. social workers, physiotherapists) (Table 1). The participants were very practiced (70.8%, 331 had more than ten years' experience) and just under half (48.2%, 226) supervised other staff. Participants commonly worked with pregnant women and babies (58.9%, 277 maternity/neonatal services), and were representative of their non-participating peers regarding age, clinical area of work, professional background and years of employment. Most participants (92.9%, 431) had been

Table 1 Personal characteristics of participating health professionals compared with the research site and the Australian population

Characteristic	No. (%) of participants	% of hospital population [a]	% of Australian hospital population
Health professional background	(*n* = 470)	(*n* = 1047)	(*n* = 251,000) [b]
Midwifery	172 (36.6)	51.0 (Nursing and Midwifery)	45 (Nursing and Midwifery)
Nursing	145 (30.9)		
Medical	69 (14.7)	19.2	12
Allied Health	61 (13.0)	10.7	14
Other	23 (4.9)	19.1	**
Age (years)			(*n* = 238,029) [c]
< 30	81 (17.2)	18.7	15.3
30–39	123 (26.2)	25.9	19.4
40–49	100 (21.3)	21.4	26.0
50–59	133 (28.3)	23.9	28.5
≥ 60	33 (7.0)	10.0	10.7
Intimate relationship status			(*n* = 15,509) [d]
Current (*n* = 430)	337 (78.4)	n.a.	65
Last 12mths (*n* = 432)	363 (84.0)	n.a.	**
Longer than 12mths (*n* = 464)	431 (92.9)	n.a.	84
Health professional experience (years) (*n* = 468)			
< 5	70 (15.0)	n.a.	**
5–9	67 (14.3)	n.a.	**
10–19	119 (25.4)	n.a.	**
20–29	99 (21.2)	n.a.	**
≥ 30	113 (24.2)	n.a.	**
Employment at hospital (years)			
< 5	197 (42.0)	50.7	**
5–9	104 (22.1)	21.9	**
10–19	94 (20.0)	16.7	**
20–29	61 (13.0)	8.7	**
≥ 30	14 (3.0)	1.9	**

Values are numbers (percentages) unless otherwise stated

Denominators vary due to missing responses

[a] Comparison female-only hospital data not available. Percentages listed above include male and female health professionals. Proportion of female clinical staff at research site hospital: 88.9%, male: 11.1%

[b] Australian male and female health professionals [43]

[c] Australian nurse/midwives [13]

[d] Population relationship data [44]

n.a. Data not collected by research site

** Comparable data not available

in an intimate relationship at some time since the age of sixteen.

Twelve-month prevalence of intimate partner violence

More than ten percent of our sample had experienced IPV in the previous 12 months; feeling afraid of a partner was reported by 5.1% (22/432), which when combined with any category of violence on the CAS, increased to 11.5% (50/434) (Table 2). The most common form of violence during the previous 12 months was Emotional Abuse/Harassment alone (6.7%, 25/375), 2.1% (8/375) had experienced Severe Combined Abuse, 2.1% (8/375) reported Physical Abuse and Emotional Abuse/Harassment, and 0.5% (2/375) reported Physical Abuse alone. Rape and/or attempted rape by an intimate partner was disclosed by 1.7% (7/375) of participants.

Adult lifetime prevalence of intimate partner violence

One in three (146/434, 33.6%) participants reported fear of a partner and/or scored as having experienced some form of violence since the age of sixteen (Table 2). The most common category of abuse was Severe Combined Abuse, 13.8% (58/421), followed by Emotional Abuse/Harassment alone, 8.1% (34/421), 4.5% (19/421) Physical abuse and Emotional Abuse/Harassment, and 3.3% (14/421) Physical Abuse alone. Around one in ten (51/421, 12.1%) participants had been raped by a partner since the age of sixteen.

Table 2 12 month and lifetime prevalence of intimate partner violence. Values are numbers (percentages) unless otherwise stated

Intimate partner violence	12 month	Adult lifetime prevalence
	n = 432	*n* = 433
Fear of partner [a]	22 (5.1)	111 (25.6)
IPV Category (CAS)	*n* = 375	*n* = 421
Severe physical, emotional and/or sexual combined abuse	8 (2.1)	58 (13.8)
Physical abuse and emotional/ harassment	8 (2.1)	19 (4.5)
Emotional abuse and/or harassment alone	25 (6.7)	34 (8.1)
Physical abuse alone	2 (0.5)	14 (3.3)
	n = 402	*n* = 421
Sexual assault (rape) by partner	7 (1.7)	51 (12.1)
	n = 434	*n* = 434
Total: Fear of partner and/or abuse	50 (11.5)	146 (33.6)

Denominators vary due to missing responses

[a] 33 participants omitted as they had never been in a relationship

Lifetime prevalence of family violence

The proportion of participants who had experienced violence by a non-intimate family member was 28.4% (133/469) (Table 3). Of this group, 12.8% (60/469) had a combined history of both IPV and FV, and 15.6% (73/469) had survived FV alone with no coexisting history of IPV.

Lifetime prevalence of other interpersonal violence

Experiences of interpersonal violence from somebody other than a partner or family member were reported by 18.7% (87/466) of participants (Table 3), and two thirds (70.2%, 61/87) of these participants had a coexisting history of intimate partner and family violence. When asked to describe the type of violence they had experienced, qualitative descriptions were categorised as follows: sexual assault (52.8%, 28/53), physical and/or combined emotional abuse (17.0%, 9/53) and emotional abuse/harassment alone (30.2%, 16/53). The perpetrator of the violence was identified as a stranger by 7.1% (4/56) of participants who provided descriptions of their experience. In contrast, the perpetrators of other interpersonal violence most frequently reported were: friends/acquaintances (29.6%, 16/54), patients (29.6%, 16/54) and colleagues (20.4%, 11/54). Males perpetrated the majority (89.7%) of the other violence described by participants.

Professional background and violence

We examined whether a participant's professional background was associated with a history of intimate partner and family violence and found that allied health professionals (65.6%, 40/61) were significantly more likely to report violence by an intimate partner or family member ($p = 0.001$) with increased odds at a level of 2.6 (CI: 1.4–4.6). This was compared to their peers in nursing/midwifery (42.5%, 134/

Table 3 Lifetime prevalence of intimate partner violence, family violence and other violence. Values are numbers (percentages) unless otherwise stated

Type of violence	Lifetime prevalence
Family violence (including witnessing parental IPV) (*n* = 469)	133 (28.4)
Childhood witnessing parental IPV only	93 (19.8)
Exposure to IPV and/or FV (*n* = 469)	212 (45.2)
Combined history of *both* IPV and FV	60 (12.8)
IPV only	79 (16.8)
FV only	73 (15.6)
Other interpersonal violence (not perpetrated by IP or family) (*n* = 466)	87 (18.7)
Other violence *only* (no combined history of IPV or FV)	26 (5.6)
Total: Lifetime interpersonal violence (by partner, family member and/or other) (*n* = 469)	238 (50.8)

Denominators vary due to missing responses

315) and medicine (44.9%, 31/69). Neither age or relationship status was significantly associated with fear or violence during the adult lifetime.

Discussion

Our study suggests that intimate partner and family violence, including sexual assault, are frequent traumas in the lives of participating women health professionals. One in ten (11.5%) health professionals had felt fear of their partner, or experienced physical, emotional and/or sexual violence from them during the previous 12 months. To put this into context, this is a substantially higher prevalence than the Australian population community sample (2.1%, N= > 17,000) [5], double the prevalence rate identified in a large workplace survey of Australian teachers and nurses (5.0%, *N* = 3611) [29], but lower than a clinical sample of patients in primary care (19.6%, *N* = 1344) [30, 31]. The community surveys have used different methodologies and may not be directly comparable with our survey; however, our findings of a lower prevalence than the clinical sample cited above validates our results, since both samples were assessed using the CAS. We would expect the 12 month rate of IPV to be lower in a sample of currently employed healthcare workers compared with a sample of unwell patients presenting to a primary care doctor with clinical symptoms, since IPV prevalence is consistently higher among those seeking health care, including primary care [32].

Across their adult lifetime, one quarter (25.6%) of participants had experienced fear of a partner, which is similar to the clinical primary care sample discussed above, where the lifetime fear of a partner was 28% (*N* = 1836) [30]. More than one in ten (12.1%) participants had been raped by their partner, which is considerably higher than both the Australian population community sample (9.2%) [5], and a large community sample of women aged 34–39 years where the prevalence (assessed by the CAS) was 6.3% (*N* = 7768) [33]. Forty-five percent of our sample (45.2%) had experienced either violence from a partner or family member, with 12.8% having experienced both. Half (50.8%) of all participants had a lifetime history of interpersonal violence, perpetrated by either a partner, family member or somebody else. These findings are difficult to place in a broader context because of difference in the measures used. They indicate however, that the violence burden in health professional women's lives may be high and overwhelmingly perpetrated by partners and family members. Further to this finding, while a fifth (19.8%) of participants identified that they had been the victim of violence by somebody outside the home, only a small proportion (5.6%) had experienced this category of violence in isolation; most survivors had a combined history of intimate partner and family violence. When asked about the perpetrator of the other violence, the majority (89.7%) were men known to the survivor: their friends, patients and colleagues.

We found that being an allied health professional was significantly associated with intimate partner and family violence. Since the majority of allied health professionals employed at the research site were social workers, and social workers are regularly referred to once a patient with a history of intimate partner and family violence is identified, they are therefore a professional group who are familiar with discussing narratives of violence [9]. Some research has indicated that people who work in the helping professions may have spent greater time confronting their personal trauma histories motivating them to support others recovering from trauma [34]. It follows then that allied health professionals may have been more willing to disclose intimate partner and family violence in this survey, or they may indeed have a higher prevalence of intimate partner and family violence. Social workers are also at higher risk of experiencing vicarious or secondary trauma from listening to the traumatic stories of their patients [35]. This warns of a potentially high cumulative trauma load stemming from the combination of primary and secondary trauma, and underscores the need for resources to assist health and other helping professionals in their work supporting patients.

Strengths of this study include the well-validated scale we used to measure IPV [27] and the representation of different health professionals. Our study is the first to publish the prevalence of IPV more than 12 months ago using the CAS, another strength of the research. The overall response rate of 45.0% is not optimal, but given the sensitive nature of this survey [36], its length, and the heavy work demands of our participants, it is comparable to similar rigorous research [12]. Other limitations of this study include; self-report and social desirability which might have led to under-reporting of violence, non-response bias and the single recruitment site which prevents generalisability of findings [37, 38]. There is the potential for recall problems with both 12 month, and lifetime measures, or “telescoping”, remembering incidents as occurring more or less than they did [39]. It is also possible that survivors of violence may be more interested and willing to participate in intimate partner and family violence research than other people [38]. These issues acknowledged, over-reporting is widely agreed to be rare in intimate partner and family violence research, while there is substantial concern about underreporting [40]. We found participants more frequently reported Emotional Abuse and/or Harassment in the previous 12 months and Severe Combined Abuse in the period longer than 12 months. Since no evidence suggests that the prevalence of emotional abuse decreases over time, we speculate that the tendency to report non-physically abusive behaviours might recede over time, indicating possible underreporting of lifetime Emotional Abuse and/or Harassment in our study.

Conclusions

Our study is the first to measure the prevalence of intimate partner and family violence in an Australian health professional population of nurses, doctors and allied health professionals. For the first time, it suggests that intimate partner and family violence may be common in the personal lives of Australian clinicians. These findings have implications for policy, practice and research. Healthcare organisations rarely consider what it means if the health professional is impacted by fear and violence in their home and are asked to intervene sensitively with patients affected by these same issues. Employment can be highly protective for someone experiencing violence [12], but it can simultaneously be a risk [41]. Attendance may be disrupted, as well as one's capacity while at work [31]. Developing a workplace program that supports health professionals with a trauma history, including their clinical practice with patients experiencing intimate partner and family violence, requires organisational leadership, guidelines for a supportive response and trained individuals to receive disclosures (peer support workers, managers/supervisors, Human Resource staff and Employee Assistance Program professionals) [9]. Workplace programs may be especially necessary given that previous research with social workers has found a greater risk of vicarious trauma in response to working with traumatised patients when the social worker has a history of childhood trauma [42]. More research is required to better understand the needs of health professional women during and after intimate partner and family violence, including the role of the workplace. Intimate partner and family violence not only impacts the health professional survivor herself, we argue that it may have important ramifications for health services' capacity to provide the best care to patients experiencing the traumatic health sequel of violence. Health services should have safe pathways to care for both health professionals and patients who are experiencing intimate partner and family violence.

Abbreviations

CAS: Composite abuse scale; FV: Family violence; IPV: Intimate partner violence

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Availability of data and materials

At present, the data and materials (survey) are not publicly available but can be obtained from the authors upon reasonable request. The Composite Abuse Scale is publically available [27].

Authors' contributions

This manuscript is part of the doctoral work of EM. EM, KH and CH participated in the design of the study. EM was primarily responsible for all aspects of the work, including data collection and analysis, with KH contributing significantly to data analysis. EM, KH and CH were all responsible for interpretation of the findings. EM wrote the manuscript, with important contributions during many reviews by KH and CH. All authors read and approved the final manuscript.

Ethics approval and consent to participate

The research was approved by both the recruiting hospital and the University of Melbourne Human Research and Ethics Committees (Ethics ID: 1339986, dated 10 May 2013). Consent to participate was implied through completed and returned surveys.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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4.3 MANUSCRIPT SUMMARY

This manuscript presented a prevalence study of DFV against an Australian population of health professional women. Recent (12-month) and adult lifetime IPV appeared to be more common among the health professional participants in this study than in the general Australian population (Australian Bureau of Statistics, 2017). However, health professional prevalence was less reported than in a community sample of women attending general practice, signalling the validity of these findings (Hegarty & Bush, 2002). Further, violence and abuse in the family of origin, and interpersonal violence outside the home, taken together with IPV, had affected as many as half of the health professional women in this study. Extra analysis will now be presented about factors related to DFV, the overlap between categories of abuse, and differences in recall of abuse over time, all of which were outside the scope of this Chapter’s published manuscript.

4.4 ADDITIONAL FINDINGS

4.4.1 IPV & health professional background

IPV during the 12-months before the survey did not differ substantially by age, professional background or relationship status (Table 11). Nor did the prevalence of adult lifetime IPV (since the age of 16 years) diverge along demographic lines (Table 12). However, allied health professionals (most of whom were social workers) were overrepresented as survivors of violence or abuse by a family member, including childhood witnessing of parental violence. DFV had affected half (50.8%, 31) of the allied health professional participants, compared to nearly a third (29.0%, 20) of doctors and a quarter (24.8%, 78) of nurses and midwives. Extending beyond the family, violence or abuse by somebody outside the home was reported by twice the number of allied health participants (31.2%, 19) than nurses and midwives (16.6%, 52) or doctors (16.2%, 11). Interpretative caution is warranted as some of the subsample groups are small, particularly of the medical and allied health professionals.

Table 11. 12-month prevalence of IPV comparing age, profession & relationship

Values are numbers (percentages) unless otherwise stated

Intimate partner violence	**12-mth prevalence**	**Age**		**Profession**			**Relationship**	
	All participants	*39 years & younger*	*40 years & older*	*Nurse/midwife*	*Medical*	*Allied Health*	*Current relationship*	*Relationship in last 12-mths*
	(*n*=432)	(*n*=192)	(*n*=240)	(*n*=285)	(*n*=68)	(*n*=57)	(*n*=336)	(*n*=429)
Fear of partner (alone)	22 (5.1)	10 (5.2)	12 (5.0)	17 (6.0)	1 (1.3)	4 (7.0)	14 (4.2)	18 (5.0)
IPV category (CAS)	(*n*=375)	(*n*=169)	(*n*=206)	(*n*=253)	(*n*=60)	(*n*=42)	(*n*=300)	(*n*=373)
Severe physical, emotional and/or sexual combined abuse	8 (2.1)	2 (1.2)	6 (2.9)	5 (2.0)	1 (1.7)	1 (2.4)	7 (2.3)	8 (2.1)
Physical abuse and emotional/harassment	8 (2.1)	4 (2.4)	4 (1.9)	5 (2.0)	1 (1.6)	2 (4.6)	5 (1.7)	8 (2.5)
Emotional abuse and/or Harassment	25 (6.7)	10 (5.9)	15 (7.3)	17 (6.7)	5 (8.2)	2 (4.7)	19 (6.3)	21 (6.5)
Physical abuse alone	2 (0.5)	1 (0.6)	1 (0.5)	1 (0.4)	1 (1.6)	0 (0.0)	2 (0.7)	2 (0.6)
	(*n*=402)	(*n*=183)	(*n*=219)	(*n*=270)	(*n*=64)	(*n*=47)	(*n*=318)	(*n*=342)
Sexual assault (rape) by intimate partner	7 (1.6)	2 (1.1)	5 (2.3)	4 (1.5)	1 (1.6)	1 (2.1)	6 (1.9)	7 (1.7)
	(*n*=434)	(*n*=194)	(*n*=240)	(*n*=287)	(*n*=68)	(*n*=57)	(*n*=337)	(*n*=363)
Total fear and/or abuse	50 (11.5)	21 (10.8)	29 (12.1)	34 (11.8)	8 (11.8)	6 (10.5)	38 (11.3)	44 (12.1)

Notes

Denominators vary due to missing responses (<5% missing data)

Table 12. Lifetime prevalence of DFV comparing age, profession & relationship
Values are numbers (percentages) unless otherwise stated

Violence and abuse	**Total prevalence**	**Age**		**Profession**			**Relationship**	
	All participants	*39 years & younger*	*40 years & older*	*Nurse/midwife*	*Medical*	*Allied Health*	*Current relationship*	*Relationship ever*
	(*n*=433)	(*n*=193)	(*n*=240)	(*n*=286)	(*n*=68)	(*n*=57)	(*n*=337)	(*n*=430)
Fear of partner (alone)	111 (25.6)	48 (24.9)	63 (26.2)	75 (26.2)	12 (17.6)	22 (38.6) *p*=0.017	80 (23.7)	111 (25.8)
Adult lifetime IPV category (CAS)	(*n*=421)	(*n*=189)	(*n*=232)	(*n*=279)	(*n*=67)	(*n*=54)	(*n*=330)	(*n*=419)
Severe physical, emotional and/or sexual combined abuse	58 (13.8)	26 (13.8)	32 (13.8)	35 (12.5)	7 (10.3)	13 (23.6) *p*=0.019	40 (12.1)	58 (13.8)
Physical abuse and emotional/harassment	21 (5.0)	10 (5.3)	11 (4.7)	14 (5.0)	2 (2.9)	5 (9.1)	15 (4.5)	21 (5.0)
Emotional abuse and/or Harassment	39 (9.3)	18 (9.5)	21 (9.1)	24 (8.6)	8 (11.8)	5 (9.1)	30 (9.0)	39 (9.3)
Physical abuse alone	14 (3.3)	6 (3.2)	8 (3.5)	9 (3.2)	3 (4.4)	1 (1.8)	12 (3.6)	14 (3.3)
	(*n*=421)	(*n*=189)	(*n*=232)	(*n*=279)	(*n*=67)	(*n*=54)	(*n*=330)	(*n*=419)
Sexual assault (rape) by intimate partner	51 (12.1)	21 (11.1)	30 (12.9)	29 (10.4)	7 (10.4)	12 (22.2) *p*=0.015	34 (10.3)	51 (12.2)
	(*n*=434)	(*n*=194)	(*n*=240)	(*n*=287)	(*n*=68)	(*n*=57)	(*n*=337)	(*n*=431)
Total fear of partner and/or abuse since age sixteen	146 (33.6)	65 (33.5)	81 (33.8)	92 (31.9)	22 (31.9)	26 (44.8) *p*=0.041	107 (31.4)	146 (33.6)
Family violence and abuse	(*n*=469)	(*n*=204)	(*n*=265)	(*n*=315)	(*n*=69)	(*n*=61)	(*n*=337)	(*n*=431)
Lifetime violence/abuse by (non-intimate) family member	133 (28.4)	56 (27.4)	77 (29.1)	78 (24.8)	20 (29.0)	31 (50.8) *p*=0.000	94 (27.9)	130 (30.2)
Witness of parental IPV	93 (19.8)	37 (18.1)	56 (21.1)	57 (18.1)	14 (20.3)	20 (32.8)	70 (20.8)	91 (21.1)
Lifetime experience of violence by an intimate partner or family member	212 (45.2)	95 (46.6)	117 (44.2)	134 (42.4)	31 (44.3)	40 (64.5) *p*=0.001	160 (42.6)	209 (47.9)
Violence and abuse outside the family	(*n*=466)	(*n*=204)	(*n*=262)	(*n*=313)	(*n*=68)	(*n*=61)	(*n*=336)	(*n*=429)
Lifetime abuse/violence by *other* (outside the family)	87 (18.7)	35 (17.2)	52 (19.8)	52 (16.6)	11 (16.2)	19 (31.2)	63 (18.7)	86 (20.0)
	(*n*=469)	(*n*=204)	(*n*=265)	(*n*=315)	(*n*=69)	(*n*=61)	(*n*=337)	(*n*=431)
Lifetime experience of abuse/violence by an intimate partner, family member or *other*	238 (50.7)	107 (52.4)	131 (49.3)	150 (47.6)	33 (47.8)	45 (73.8)	179 (53.1)	234 (54.3)

Notes
IPV prevalence since 16 years of age
Denominators vary due to missing responses (<5 missing data)

4.4.2 Overlap in experiences of DFV

There was significant overlap in experiences of IPV, non-intimate family violence, and violence outside the home. Of the health professionals who had experienced DFV (IPV *and* non-intimate partner FV), 28.4% (133) had experienced *both* violence or abuse in their family of origin, as well as violence by an intimate partner in adulthood (Figure 10). Using logistic regression, the predicted odds of reporting violence or abuse by a family member in childhood were two and a half to three times greater if the female health professional had experienced IPV during the last 12-months (OR 2.5, 95% CI 1.3 to 5.1) or since the age of 16 years (OR 3.0, 95% CI 1.9 to 4.9). While this could not be directly investigated, a life course effect is indicated by these findings, suggesting that the experience of child abuse may influence future abuse experiences.

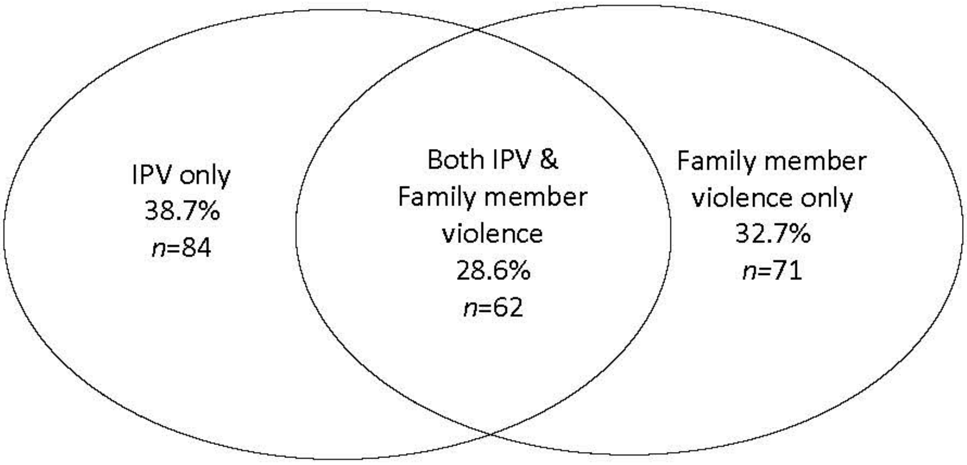

Figure 10. Overlap in experiences of lifetime IPV & family member violence
(n=217)

Similarly, having a history of DFV was associated with abuse or violence outside the home (Figure 11). Specifically, the odds that a health professional had experienced violence or abuse outside the home were three and a half times greater for DFV survivors (OR: 3.5, 95% CI 2.1, 5.8) than others. By including women who had experienced violence outside the home, the overall prevalence of exposure to some form of interpersonal violence (intimate partner, family and/or other person) across the whole sample rose to 50.7% (238), while for the sub-group of allied health participants, three quarters had experienced one or more types of violence (73.8%, 31).

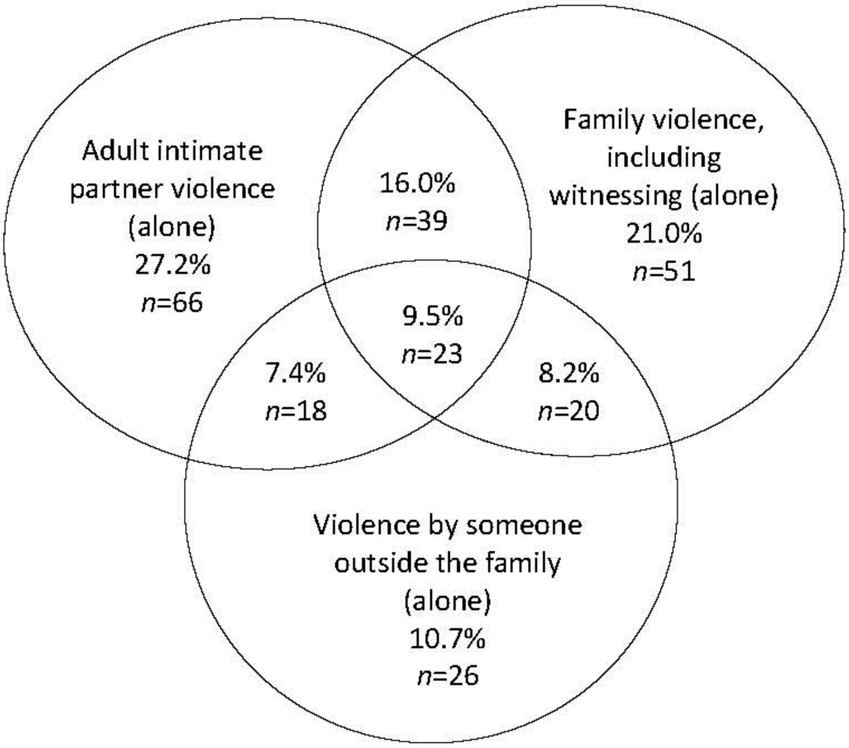

Figure 11. Overlap in experiences of IPV, family member violence & other interpersonal abuse for all female health professionals

(n=243)

4.4.3 Recall of abuse over time

This study found a difference in the type of IPV that women recalled when asked about the last 12-months compared to a longer period of time. Recall of abuse can be a methodological issue, and in that context will be briefly discussed in the final Chapter (see page 200). However, the purpose of discussing the observed differences in types of IPV recalled over time in this Results Chapter, is in an attempt to better understand how participants think about and recount information from their past for the purposes of research. As Figure 12 portrays, for survivors whose abuse had occurred in the last 12-months, close to 60% (58.3%) were categorised via the CAS as having experienced emotional abuse or harassment. The remaining abuse (41.7%) was physical and sexual combined abuse. Whereas, those recall categories were reversed for IPV longer than 12-

month in the past. During this longer timeframe, nearly 65% (64.3%) of adult lifetime abuse recalled was physical and sexual combined, compared to 35% (35.7%) for emotionally abusive and harassing behaviours.

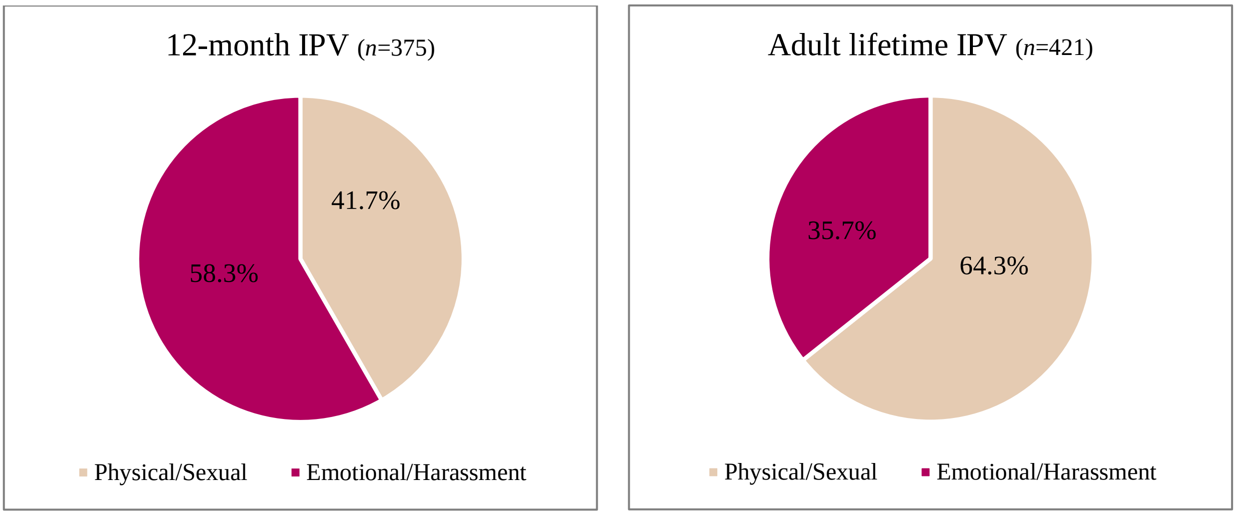

Figure 12. Categories of abuse recalled over time

In the absence of any evidence to suggest that types of abuse change over time, what might change is one’s recall of types of abuse. However, this is not the same issue as memory fallibility, a well-known concern driving short recall periods in research (Smith, 1987). It has been suggested that over time survivors might “reinterpret events”, later viewing some as “not violent enough” to report to researchers (Australian Institute of Health and Welfare 2018, p. 71). In other words, survivors might prioritise the recounting of certain types of abuse, or memories from the past might feature some abusive behaviours more prominently than others. Whereas, when recounting behaviours in a relationship during the previous 12-months, since there are less memories to shift through given the shorter timeframe, a survivor may be more inclusive of her entire experience. Without evidence to suggest that survivors who have been in an abusive relationship for longer than 12-months experience non-physically abusive behaviours less over time, the recall differences arising in this study may indicate the underreporting of lifetime Emotional Abuse and/or Harassment.

4.4.4 Staff survivors' comments within the survey

Of note, many survivor health professional participants wrote extensively about their personal experiences of abuse and violence in the survey. Sometimes, these comments were in response to an open-ended survey question or open text field, while other times, descriptions of experience were peppered in the survey margins or on the cover of the physical surveys. This suggested that some survivor participants wanted to tell a longer narrative about their abusive experience than was asked for by the survey, and anecdotally, is a common aspect of survey research. It was only within the scope of this PhD to draw out and analyse participants' descriptions of their abusive experiences where they were relevant to their workplace (see Chapter 6). Nevertheless, the survivor stories of lived experience were often powerful, speaking to the resilience of the writer and they impacted upon me, their reader.

4.5 CONCLUSION

This first Results Chapter presented key findings related to research question one of this thesis about the prevalence of DFV against Australian health professional women. The Chapter included a published manuscript as well as further analysis. Family and other violence and abuse was associated with health professional background, with allied health professionals more likely than their nursing and medical colleagues to report both violence in their family of origin and outside of the family, but no more likely to have experienced 12-month or adult lifetime IPV. Overall, the results indicate that the violence and abuse burden for Australian health professional women may be high and overwhelming perpetrated at home. An exploration of contributing factors to the observed differences in the type of abuse recalled over time was presented. The next Results Chapter investigates whether health professional exposure to DFV is associated with clinical care of survivor patients.

5.

Clinical care impacts study

“[I want] *time to debrief after talking to a woman who has disclosed a domestic or sexual violence issue, so I am not left worrying about the person. I deliberately avoided a* [DFV] *work presentation, afraid of the issues it might bring up for me. I did not want to think about them, especially the worst domestic violence and sexual violence of past relationships and as a child. There would be no one to talk to if I did become upset so I’d probably have to bottle it up …”*

(Survivor health professional participant)

“They [staff who have experienced DFV] *need to be resourced in the name of the* [hospital]. *So that it then says, you're an employee of the* [hospital], *the* [hospital] *cares enough about you to want you to do something about it.”*

(Hospital manager participant)

5.1 OVERVIEW

This second Results Chapter answers the research question: *Do health professional's personal experiences of DFV affect their attitudes about DFV, comfort to discuss the issue with women, enquiry and response towards survivor women?* The findings are presented in the second manuscript that was published during candidature. This was an investigation, using linear and logistic regression, of the associations between health professional exposure to DFV and clinical care of survivor patients. The areas of most focus were differences on specific measures of preparedness (training and attitudes), patient identification, and clinical responses following disclosure. In this manuscript, the background evidence is presented, along with an overview of the methods, the findings and finally, their context is placed within a discussion. This manuscript was published in *BMJ Open* in June 2019. As the lead author, I wrote 90% or more of this paper, with important contributions on all aspects of its content from my co-author supervisors. All authors read and approved the final manuscript prior to submission. The language used to describe DFV in this manuscript is *domestic violence*, in line with the editorial decision of the journal. The term 'DV' is intended to denote DFV. The manuscript was accompanied by a STROBE Statement (Appendix V). Additional data and analysis relevant to the clinical care impact of DFV against health professional women that was not able to be included in this manuscript is added as a final section after the PDF.

5.2 PUBLISHED RESULTS MANUSCRIPT (PAPER 2)

Open access Research

BMJ Open

Is a clinician's personal history of domestic violence associated with their clinical care of patients: a cross-sectional study

Elizabeth McLindon,[1,2] Cathy Humphreys,[3] Kelsey Hegarty[1,2]

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ABSTRACT

Objective To investigate whether domestic violence (DV) impacts on health professionals' clinical care of DV survivor patients.

Design, setting Descriptive, cross-sectional study at an Australian tertiary maternity hospital.

Participants 471 participating female health professionals (45.0% response rate).

Outcome measures Using logistic and linear regression, we examined whether health professionals' exposure to lifetime DV was associated with their clinical care on specific measures of training, attitudes, identification and intervention.

Results DV survivor health professionals report greater preparedness to intervene with survivor patients in a way that is consistent with ideal clinical care. This indicates that personal DV experience is not a barrier, and may be a facilitator, to clinical care of survivor patients.

Conclusions Health professionals are at the front line of identifying and responding to patients who have experienced DV. These findings provide evidence that survivor health professionals may be a strength to the healthcare organisations in which they work since among the participants in this study, they appear to be doing more of the work seen as better clinical care of survivor patients. We discuss the need for greater workplace supports aimed at promoting safety and recovery from violence and strengthening clinical practice with patients.

Strengths and limitations of this study

- Adjustment for potential confounders in regression rendering it distinct in this under-researched field; the inclusion of health professionals from all clinical backgrounds reflected in hospitals, and the recruitment of primary domestic violence (DV) health professional survivors.
- The single recruitment site that prevents generalisation of the findings, and survey self-report and social desirability, which may have led to the under-reporting of DV.
- While our 45.0% response rate is not ideal, considering the work demands of the nursing and medical participants in this study, and the representational participation of nurses, doctors and allied health professionals, we argue that our response rate is both acceptable and comparable to similar research.

BACKGROUND

Domestic violence (DV), including intimate partner, family violence and sexual assault, are common traumas for Australian female nurses, doctors and allied health professionals.[1] DV is a global public health issue, defined by WHO as 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship'.[2] It can encompass partner violence, child abuse or abuse by any member of a household.[2] Throughout this paper, we use the term 'DV' to refer to violence by a partner or a family member and 'survivor' when referring to someone (health professional or patient) who has experienced DV.[3]

Women who have survived DV have poorer physical and psychological health, requiring more healthcare than non-abused women.[4] Australian women's lifetime prevalence of physical or sexual violence by an intimate partner is 25%, with 2.1% experiencing violence in the last 12 months.[5] A recent study of 471 Australian female health professionals found that the prevalence of intimate partner violence was higher than in the general community, and lower than among unwell women attending a general practitioner, with a lifetime prevalence of 33.6%, while the 12-month prevalence was 11.5%.[1] The lifetime prevalence of DV (violence by a partner and/or other family member) was 45.2%.[1]

The role of the health system and health professionals is to identify survivor patients and provide a timely, evidence-based response.[6] There is mixed evidence about whether health professionals' personal experiences of DV have an impact on the clinical care of their survivor patients.[7–15] An extensive search of the academic literature identified four surveys about survivor health

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professionals' clinical care of survivor patients.[7 8 10 15] Two of these studies found that survivor health professionals performed more DV screening and raised DV with survivor patients more frequently during follow-up visits.[7 8] However, the other two studies found no association between DV experience and clinical care.[10 15] There were problems with three of these four studies.[7 8 10] For example, two did not adjust for potentially confounding factors in their analysis,[7 8] and the third, now nearly 20 years old, defined their survivor exposure group based on only two non-validated DV questions.[10] The strongest research to date surveyed Swedish health professionals (n=588).[15] After adjusting for professional background, experience and training, it found that care of survivor patients was not associated with personal experience of DV, however, DV training was positively associated with all aspects of care and knowledge.[15] Another four studies about clinical care of survivor patients have been from the perspective of health professionals whose DV exposure was through family, friends or patients.[9 11 13 14] We argue that the need for a more rigorous study is evident.

METHODS

Aim, design and setting

The objective of this study was to address a gap in the available evidence about whether Australian health professional's personal history of DV is associated with their clinical care of survivor patients. The research question at the outset of this project was: Is personal experience of DV associated with a health professional's attitudes about DV survivor patients and the role of the health workplace; identification of survivor patients; comfort to discuss DV and clinical interventions with survivor patients? We hypothesised that, after adjusting for possible confounding background variables, compared with their non-abused peers, survivor health professionals would: (1) demonstrate more sensitive attitudes about survivors; (2) feel more comfortable discussing DV and sexual assault with their patients; (3) ask more patients about DV; (4) identify more survivors within a 6-month period and (5) provide more DV interventions to survivor patients, including DV referral. While not an initial focus of the study, the effect of training on clinical practice emerged as an interesting finding during the data analysis and was included in the results.

A full description of the study design, setting, participants and recruitment process has been reported previously in a paper about prevalence.[1] In brief, we conducted an anonymous and voluntary cross-sectional survey of all health professionals in one Australian tertiary maternity hospital between 8 August and 31 December 2013. Participants were female health professionals (nurses, doctors and social workers) working with patients. An online survey link and encouragement to participate by the chief executive officer was distributed via email to all part-time/permanent clinical staff—nurse/midwives, doctors and allied health professionals. Staff were ineligible to participate if they were employed casually or did not work in a clinical capacity (ie, administration staff).

Data collection and measures

Exposure to DV encompassed 12 month and adult lifetime intimate partner violence and/or lifetime violence by a family member. Violence by an intimate partner was measured using the Composite Abuse Scale, a well-validated and widely used self-report measure of physically, sexually and emotionally abusive behaviours perpetrated by an intimate partner.[16] This was measured by: scoring on the 12-month subscales, or two of the lifetime subscales, 'Severe Combined Abuse' or 'Physical and Emotional Abuse', or by scoring >7. Violence by a family member was measured by answering positively to either of two questions about lifetime physical, emotional and sexual abuse by a family member and witnessing parental abuse. Overall, 45.2% (212/471) of the female participants in this sample qualified for inclusion into the DV exposure group.[1]

The main predictor variable was exposure to DV. In a follow-up analysis, the predictor variables were DV training and demographics. The outcome variables were: attitudes (measured by Physician Readiness to Manage Intimate Partner Violence Survey,[17] comfort discussing DV, DV inquiry and interventions after identifying a new DV case during a 6-month period (table 1). Adjustment for potential confounding variables was made a priori based on the literature, and included: age (40+ years),[14 18] professional background (allied health),[10 14] DV training (1+ days)[9 10 15] and years of clinical experience (10+ years).[14 15]

Statistical analysis

Clinical interventions to identify and respond to DV were summarised using frequencies and percentages for categorical data and means and SD for ordinal data. Independent t-tests and X^2 tests of comparison were used to compare mean scores. Linear regression compared differences in mean scores across exposure for attitude scores, while logistic regression was used for comfort asking about DV and clinical intervention variables. ORs, 95% CIs and p values were used to assess the likely size of the association between each clinical action and DV.

Data were analysed with STATA V.13.1.[20]

Patient and public involvement

No patients or the public were involved in developing the research question or outcome measures. Health professionals were involved, however, and they were informed by their clinical work with survivor patients. Health professionals contributed to the research questions and overall design of the study. Results of the study will be disseminated to participants via workplace newsletter items and staff public speaking forums at the recruitment site.

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Table 1 Variables included in analysis*

	Description
Independent variables	
Exposure to DV†	30 CAS items measured 12 month and lifetime intimate partner violence and 2 family violence questions.
DV training‡§	6 items measured graduate and postgraduate DV training history (<8 hours‡/>8 hours).¶
Demographics**	3 items measured: age (<40 years/>40 years), professional background (medical/nursing/allied health) and years of clinical experience (<20 years/>20 years).
Dependent variables	
Attitudes††	12 PREMIS items comprised two subscales; ‘Victim understanding’ (attitudes about survivors) and ‘Workplace issues’ (attitudes about the role of the workplace). Scoring via a 7-point Likert-type scale, with some items reverse scored due to intentional negative wording.
Comfort discussing DV§	4 items scored on a 5-point Likert-type scale measured comfort to discuss DV and sexual assault with patients (‘comfortable’/‘uncomfortable’). 4 items scored on a 6-point Likert-type scale measured: ‘Did not avoid issue of DV’, ‘Did not find DV upsetting to talk about’, ‘Very aware of the issue’ and ‘Tried to go the extra mile with patients’ (‘agree’/‘disagree’). Some items reverse scored due to intentional negative wording.
DV inquiry§	1 item scored on a 5-point Likert-type scale measured frequency of asking all patients about DV (‘never’/‘ever’) during the previous 6 months.
	5 items measured identification of 1+ new patient survivor/s (‘0 new cases’/‘1+ new cases’) in the previous 6 months.
Interventions after identifying a new DV case§	10 items scored on a 5-point Likert-type scale measured: risk assessment, safety planning, case file documentation, use of clinical guideline, access of DV information to give to patients, clinical discussion at team meeting and with manager and DV referrals (‘never’/‘1–3+ times’) during the previous 6 months.
Variables used for adjustment§	
Age	>40 years
Professional background	Allied health: social workers were the most common allied health professionals at this hospital and it was anticipated that they would likely have been in receipt of greater undergraduate and professional DV training.
DV training	>8 hours
Years of clinical experience	>10 years

*All items/measures were made into binary variables unless otherwise noted.
†Exposure to DV measured via CAS.[16]
‡Training also analysed as an outcome (dependent) variable.
§Bespoke item developed for the survey based on an extensive review of the literature.
¶Participants with no DV training were included in ‘<8 hours’.
**Demographic measures based on recruitment site specific data and Australian Institute of Health and Welfare.[19]
††Attitudes measured via PREMIS.[17]
CAS, Composite Abuse Scale; DV, domestic violence; PREMIS, Physician Readiness to Manage Intimate Partner Violence Survey.

RESULTS

Participant characteristics

The survey was sent to 1047 female health professional staff and 471 participated: 366 completed the survey electronically, while 105 returned a paper version, giving a response rate of 45.0%. Most participants were nurse/midwives, aged 30–60 years, had 10 or more years of experience, and were demographically representative of their non-participating peers (table 2). Survivor health professional participants (45.2%, 212/469) were significantly more likely to be aged 30–39 years and have an allied health background compared to participants who were not survivors.[1]

Training and preparedness

Survivor health professionals were more likely to have received one or more days of DV training (adj OR 1.9, 95% CI 1.2 to 3.2) and to report more sensitive attitudes about DV survivors (adj. coef. 0.2, 95% CI 0.1 to 0.4) compared with their colleagues who had not experienced DV. Survivor health professionals were no more likely than others to find it upsetting to talk about DV with their patients (adj OR 0.8, 95% CI 0.5 to 1.1)

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Table 2 Personal characteristics of participating health professionals

Characteristic	Total participants* (n=471) n (%)	No history of violence (n=257) n (%)	Lifetime domestic violence (n=212) n (%)	P value
Age (years)				
<30	81 (17.2)	52 (20.2)	29 (13.7)	0.063
30–39	123 (26.2)	57 (22.2)	66 (31.1)	0.029
40–49	100 (21.3)	54 (21.0)	46 (21.7)	0.857
50–59	133 (28.3)	70 (27.2)	62 (29.2)	0.630
≥60	33 (7.0)	24 (9.3)	9 (4.2)	0.036
Health professional background				
Nursing/midwifery	317 (67.5)	181 (70.7)	134 (63.2)	0.086
Medical	69 (14.7)	38 (14.8)	31 (14.6)	0.946
Allied health	61 (13.0)	21 (8.2)	40 (18.9)	0.001
Other†	23 (4.9)	16 (6.3)	7 (3.3)	0.148
Years of clinical experience				
<5	70 (15.0)	39 (15.4)	31 (14.6)	0.826
5–9	67 (14.3)	35 (13.8)	32 (15.1)	0.687
10–19	119 (25.4)	62 (24.4)	57 (26.9)	0.542
20–29	99 (21.2)	53 (20.9)	45 (21.2)	0.924
≥30	113 (24.2)	65 (25.6)	47 (22.2)	0.390
Participants who supervise other staff	226 (48.2)	122 (47.8)	102 (48.1)	0.954
Adult intimate relationship (ever)‡	431 (92.9)	222 (88.1)	209 (98.6)	<0.01

*Denominators vary due to missing responses. Maximum missing data n=3 (0.6%).
†Health professionals working in a clinical role not already specified, that is, imaging, pharmacy.
‡33 participants were omitted from relationship questions because they had never been in a relationship.

(table 3). Irrespective of whether a health professional had experienced DV, having undertaken at least 1 day of DV training was positively associated with good clinical care, including identifying survivor patients (adj OR 9.6, 95% CI 5.0 to 18.8), risk assessment (adj OR 4.6, 95% CI 2.2 to 9.5), safety planning (adj OR 4.3, 95% CI 2.1 to 8.9) and referral (adj OR 2.1, 95% CI 1.0 to 4.1). This finding occurred even after adjustment for possible confounders (table 4). Univariate analysis suggested a positive association between hours of DV training and asking patients about the issue. The analysis also suggested that allied health professional participants (ie, social workers) were more likely to have had 1+ days of DV training and to have safety planned and referred survivor patients than the other professional groups (table 4).

Identifying survivor patients

In the unadjusted analysis, being a survivor health professional was associated with asking patients about DV during the previous 6 months and motivation ‘to go the extra mile’ with them. However, in the adjusted analysis a between-group difference did not remain, although the significance level for asking patients about DV was approaching 0.05 (adj OR 1.5, 95% CI 1.0 to 2.3, p=0.07) (table 3).

Clinical care

Of the 193 participants who identified a survivor patient in the last 6 months, the unadjusted results indicated that survivor health professionals were more likely than others to have provided DV information to patients, conducted risk assessments, safety plans and made referrals to services (table 3). However, in the adjusted analysis, the only association that remained was accessing DV information for patients (adj OR 2.0, 95% CI 1.0 to 4.0).

DISCUSSION

These findings provide evidence that survivor health professionals may be doing more of the work seen as better clinical care of survivor patients than those without personal experience. Being a survivor health professional was significantly associated with uptake of DV training, more sensitive attitudes about survivors and a higher likelihood of having accessed DV information to give to survivor patients, which supports the hypothesis that survivor health professionals would demonstrate more sensitive attitudes about survivors compared with their non-abused peers. There was only partial support for the hypothesis that survivor health professionals would recall

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Table 3 Health professional's personal exposure to DV and their clinical practice

	All participants (n=471)*	Lifetime abuse by partner/family member No abuse (n=257)	Lifetime abuse by partner/family member Abuse (n=212)	Unadjusted	Adjusted†	P values
	n (%)			OR (95% CI)		
Training (1+ days)	94 (20.1)	36 (14.1)	58 (27.4)	2.3 (1.4 to 3.6)	1.9 (1.2 to 3.2)	0.007
Preparedness for practice	Mean (SD)			Coef (95% CI)		
Attitudes about survivors	5.1 (1.0)	4.9 (1.0)	5.3 (0.9)	0.3 (0.2 to 0.5)	0.2 (0.1 to 0.4)	0.009
Attitudes about the role of health services	4.4 (1.1)	4.3 (1.0)	4.4 (1.2)	0.1 (–0.1 to 0.3)	–0.1 (–0.3 to 0.1)	0.550
	n (%)			OR (95% CI)		
Recent clinical practice‡	(n=422)	(n=226)	(n=194)			
Comfort discussing DV	194 (46.0)	94 (41.6)	99 (51.0)	1.5 (1.0 to 2.2)	1.1 (0.7 to 1.7)	0.578
Comfort discussing sexual assault	165 (39.0)	77 (34.1)	87 (44.8)	1.6 (1.1 to 2.3)	1.2 (0.8 to 1.8)	0.455
Did not avoid issue of DV	254 (61.9)	93 (42.5)	62 (32.8)	1.5 (1.0 to 2.3)	1.3 (0.8 to 2.0)	0.232
Did not find upsetting to talk about	229 (55.8)	127 (56.0)	102 (54.0)	0.8 (0.6 to 1.2)	0.8 (0.5 to 1.1)	.186
Very aware of the issue	220 (54.3)	107 (50.0)	111 (59.0)	1.4 (1.0 to 2.1)	1.2 (0.8 to 1.8)	0.399
Tried to go the extra mile with patients	181 (44.5)	84 (38.7)	95 (50.3)	1.6 (1.1 to 2.4)	1.3 (0.9 to 2.0)	0.205
DV inquiry						
Inquiry of 1+ patient/s	260 (61.6)	124 (54.9)	134 (69.1)	1.8 (1.2 to 2.7)	1.5 (1.0 to 2.3)	0.074
Identified 1+ new cases	193 (45.7)	91 (40.1)	101 (52.3)	1.6 (1.1 to 2.4)	1.3 (0.8 to 2.0)	0.263
Intervention/s with survivor patients§	(n=193)	(n=91)	(n=101)			
Risk assessment	102 (53.7)	41 (46.1)	60 (60.0)	1.8 (1.0 to 3.1)	1.2 (0.6 to 2.4)	0.501
Safety planning	80 (41.7)	28 (31.1)	52 (51.5)	2.3 (1.3 to 4.2)	1.6 (0.8 to 3.2)	0.208
Case file documentation	139 (72.4)	63 (70.0)	75 (74.3)	1.2 (0.6 to 2.3)	1.1 (0.5 to 2.2)	0.786
Utilised DV clinical practice guideline	76 (40.0)	37 (41.1)	38 (38.4)	0.9 (0.5 to 1.6)	0.7 (0.4 to 1.4)	0.363
Accessed DV information	60 (31.4)	22 (24.4)	37 (37.0)	1.8 (1.0 to 3.4)	2.0 (1.0 to 4.0)	0.040
Discussed DV at a team meeting	125 (66.1)	56 (62.2)	68 (69.4)	1.4 (0.7 to 2.5)	1.2 (0.6 to 2.3)	.542
Discussed a DV case with manager	146 (76.4)	66 (74.2)	79 (78.2)	1.2 (0.6 to 2.4)	1.1 (0.5 to 2.3)	0.751
DV referrals						
Internal hospital service	166 (86.0)	78 (85.7)	87 (86.1)	1.0 (0.5 to 2.3)	1.0 (0.4 to 2.5)	0.960
Community DV service	78 (40.6)	30 (33.3)	48 (47.5)	1.8 (1.0 to 3.3)	1.3 (0.7 to 2.7)	0.387

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Table 3 Continued

	All participants (n=471)*	Lifetime abuse by partner/family member		Unadjusted	Adjusted†	P values
		No abuse (n=257)	Abuse (n=212)			

*Denominators vary due to missing values, maximum missing values n=19 (4.0%).
†Adjusted for age (40+ years), profession (social work), years of clinical experience (10+ years), training (1+ days).
‡During the last 6 months. 48 participants were excluded from the remaining analyses because they had not been in clinical practice.
§277 participants were excluded from analyses (229 participants who had not identified a new DV case and 48 participants not in clinical practice).
DV, domestic violence.

providing more DV interventions to survivor patients since the only significant association was having accessed more DV information for patients. However, the hypotheses that survivor health professionals would feel more comfortable discussing DV with their patients, ask more patients about DV, and identify more survivors within a 6-month period, were not supported after adjusting for age, years of experience and training. It is notable that survivor health professionals asked more patients about DV at a level approaching significance.

Strengths and limitations

Strengths of this study include adjustment for potential confounders in regression,[7 8 11 13 14] the inclusion of health professionals from all clinical backgrounds reflected in hospitals[7 8 10–14] and the recruitment of primary DV survivors.[9 11 13 14] Limitations of this study include self-report and social desirability, which may have led to under-reporting of abuse, and the single recruitment site that prevents generalisability of findings.[21 22] It is possible that DV survivors were more motivated to participate in the project than the other people,[21] and we acknowledge the possibility that non-respondents may have differed from respondents in a way that affected our conclusions. Considerable attempts were made to address selection bias by active recruitment and strong encouragement to participate; a 45.0% response rate was achieved. Despite the sample limitations, considering the work demands of our participants and the representational participation of nurses, doctors and allied health professionals, we argue that our response rate is acceptable and comparable to similar research.[7 8]

The study in the context of other studies

The finding of an association between a health professional's history of DV and aspects of clinical care of survivor patients echoes other research.[7 14] A possible interaction between DV training, personal experience and clinical care has been suggested previously.[9] However, the finding in this study of a relationship between a health professional's history of DV and their participation in training is critical and new. This finding was surprising; we did not posit a hypothesis about survivors accessing more hours of professional training. We suggest that survivor health professionals may be more likely to attend training because they understand the issue, resultant impact on health and the need for timely responses, and/or they are seeking information or validation about their own experience.

The association between being a survivor health professional, holding more sensitive attitudes about survivors and providing DV information to patients is consistent with one previous study.[14] This small study examined nurses' thoughts, feelings and proposed actions in response to identifying survivor patients, finding an association between being a survivor nurse and having more sensitive, empathetic responses to survivor patients.[14] Our study extends these findings since that analysis did not

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Table 4 The effect of training on clinical practice

	All participants (n=471)*	Length of training		Unadjusted	Adjusted†	P values
		<1 day (n=375)	1+ day (n=94)			
	n (%)			OR (95% CI)		
Demographics						
Age						
<40 years	204 (43.4)	169 (45.2)	33 (35.1)	0.7 (0.4 to 1.0)	0.6 (0.3 to 1.1)	0.090
>40+ years	266 (56.6)	205 (54.8)	61 (64.9)	1.5 (0.9 to 2.4)	1.8 (0.9 to 3.4)	0.090
Professional background						
Nursing/midwifery	317 (67.5)	268 (71.7)	48 (51.1)	0.4 (0.3 to 0.6)	0.4 (0.2 to 0.6)	0.000
Medical	69 (14.7)	55 (14.7)	13 (13.8)	0.9 (0.5 to 1.8)	0.9 (0.5 to 1.8)	0.816
Allied health	61 (13.0)	31 (8.3)	30 (31.9)	5.2 (2.9 to 9.1)	5.3 (3.0 to 9.4)	0.000
Years of clinical experience						
<20 years	256 (54.7)	207 (55.6)	47 (50.0)	0.8 (0.5 to 1.2)	0.6 (0.3 to 0.9)	0.028
>20+ years	212 (45.3)	165 (44.3)	47 (50.0)	1.2 (0.8 to 2.0)	1.7 (1.1 to 2.9)	0.028
Supervision of other staff	226 (48.2)	175 (46.9)	49 (52.1)	1.2 (0.8 to 1.9)	1.7 (1.0 to 2.9)	0.038
Preparedness for practice	Mean (SD)			Coef (95% CI)		
Attitudes about survivors	5.1 (1.0)	4.9 (1.0)	5.8 (0.7)	0.9 (0.6 to 1.1)	0.8 (0.6 to 1.1)	0.000
Attitudes about the role of health services	4.4 (1.1)	4.2 (1.0)	5.0 (1.2)	0.8 (0.6 to 1.1)	0.7 (0.4 to 0.9)	0.000
	n (%)			OR (95% CI)		
Recent clinical practice‡	(n=422)	(n=336)	(n=84)			
Comfort discussing DV	194 (45.9)	125 (37.1)	68 (80.9)	7.2 (4.0 to 13.0)	6.4 (3.5 to 11.8)	0.000
Comfort discussing sexual assault	165 (39.0)	104 (30.9)	61 (72.6)	5.9 (3.5 to 10.1)	5.1 (2.9 to 8.9)	0.000
Did not avoid issue of DV	254 (61.9)	190 (58.5)	63 (75.9)	2.3 (1.3 to 3.9)	2.2 (1.2 to 3.9)	0.008
Did not find upsetting to talk about	229 (55.8)	173 (53.2)	54 (65.1)	1.6 (1.0 to 2,7)	1.6 (0.9 to 2.7)	0.095
Very aware of the issue	220 (54.3)	149 (46.4)	70 (85.4)	6.7 (3.5 to 12.9)	7.0 (3.5 to 13.7)	0.000
Tried to go the extra mile with patients	181 (44.5)	118 (36.5)	62 (75.6)	5.4 (3.1 to 9.3)	5.0 (2.8 to 8.9)	0.000
DV inquiry						
Inquiry of 1+ patient/s	260 (61.6)	178 (53.0)	81 (96.4)	24.0 (7.4 to 77.4)	24.1 (7.3 to 78.8)	0.000
Identified 1+ new cases	193 (45.7)	121 (35.9)	71 (85.5)	10.6 (5.5 to 20.2)	9.6 (5.0 to 18.8)	0.000
Intervention/s with survivor patients§	(n=193)	(n=121)	(n=71)			
Risk assessment	102 (53.7)	47 (39.5)	54 (77.1)	5.2 (2.6 to 10.1)	4.6 (2.2 to 9.5)	0.000
Safety planning	80 (41.7)	31 (25.8)	48 (67.6)	6.0 (3.1 to 11.4)	4.3 (2.1 to 8.9)	0.000

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Table 4 Continued

	All participants (n=471)*	Length of training <1 day (n=375)	1+ day (n=94)	Unadjusted	Adjusted†	P values
Case file documentation	139 (72.4)	76 (63.3)	62 (87.3)	4.0 (1.8 to 8.8)	3.4 (1.5 to 7.8)	0.004
Utilised DV clinical practice guideline	76 (40.0)	32 (26.9)	43 (61.4)	4.3 (2.3 to 8.1)	4.2 (2.1 to 8.3)	0.000
Accessed DV information	60 (31.4)	32 (26.7)	27 (38.6)	1.7 (0.9 to 3.2)	1.7 (0.9 to 3.4)	0.120
Discussed DV at a team meeting	125 (66.1)	69 (59.0)	55 (77.5)	2.4 (1.2 to 4.7)	2.4 (1.1 to 5.0)	0.019
Discussed a DV case with manager	146 (76.4)	82 (68.9)	63 (88.7)	3.5 (1.5 to 8.2)	3.3 (1.4 to 8.1)	0.007
DV referrals						
Internal hospital service	166 (86.0)	97 (80.2)	68 (95.8)	5.6 (1.6 to 19.4)	6.4 (1.7 to 23.6)	0.005
Community DV service	78 (40.6)	35 (29.2)	42 (59.1)	3.5 (1.9 to 6.5)	2.1 (1.0 to 4.1)	0.042

*Denominators vary due to missing value. Maximum missing data n=3 (1.5%), unless otherwise specified.
†Adjusted for age (40 years and older), profession (social work) and years of clinical experience (10 or more years).
‡During the last 6 months, 48 participants were excluded from the remaining analyses because they had not been in clinical practice.
§277 participants were excluded from analyses (229 participants who had not identified a new DV case and 48 participants not in clinical practice).
DV, domestic violence.

adjust for potential confounders and the exposure group included health professional participants with secondary exposure to DV through friends/family. We postulate that survivor health professionals may hold more sensitive attitudes about survivors and fewer misconceptions about DV because of empathy stemming from a shared trauma experience. Additionally, they may be more likely to access DV information for their patients because they believe that DV awareness is an important intervention in itself.

Implications

Given the association between being a survivor health professional and attendance at DV training, this should be regarded when developing and delivering DV training for health professionals.[7] Such training could incorporate reflection, safety information, emotional health psychoeducation, referral, workplace support and promoting a safe and supportive healthcare workplace.[15 23] More broadly, these findings provide evidence that survivor health professionals are an asset to the organisations in which they work since among the participants in this study, they appear to be doing more of the work seen as better clinical care of survivor patients. This finding rebukes the misconception that women who have experienced DV are enduringly vulnerable, a distortion which can encourage women to remain silent, especially at work, for fear of how they might be regarded if they speak up.[24] This study presents an opportunity for health services to explore how the lived experience of DV for both their patient and staff survivors could inform and improve their service. A past critique of health and other 'mainstream' DV response services has been that they have not meaningfully consulted survivors.[25] Listening to the experiences and needs of survivor health professionals may enhance the support those health professionals feel from their employer, strengthening their personal and professional capacity as they care for patients. There is evidence that accessing support for DV can result in meaningful change in survivors' lives, including in their employment.[18] We argue the need for greater workplace supports aimed at promoting safety and recovery from violence and strengthening clinical practice with patients. This requires organisational leadership, evidence-based response guidelines and resourced individuals to whom a disclosure can be made and who can provide varied levels of support (resource information, clinical debriefing, longer term emotional support).[1] Trauma-informed care may provide a useful framework to guide the response of hospitals towards better supporting staff and patient DV survivors.[26] A trauma-informed system is one in which all components have been organised with the understanding that trauma is a centralising influence in survivor's lives, and organisational, operational and clinical practice should prioritise safety, control and the recovery trajectory.[27] More research is required to better understand the impact of DV workplace supports for DV on health professional women's well-being and clinical care. This

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study sheds light on the survivor experience, especially for women at work.

CONCLUSION

This research demonstrates that health professionals with a lived experience of DV attend more training aimed at improving clinical care of survivor patients, self-report more sensitive attitudes about survivors and access more DV information for patients after disclosure. This suggests that DV is not a barrier, and may be a facilitator, to clinical care of survivor patients. Healthcare workplaces should take account of this in their response to survivor health professionals, the development of DV training offered to staff, clinical care policies with patients and workplace supports.

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Contributors This manuscript is part of the doctoral work of EM. EM, KH and CH participated in the design of the study. EM was primarily responsible for all aspects of the work, including data collection and analysis, with KH contributing significantly to the data analysis. EM, KH and CH were all responsible for interpretation of the findings. EM wrote the manuscript, with important contributions during many reviews by KH and CH. All authors read and approved the final manuscript.

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Data sharing statement At present, the data and materials (survey) are not publicly available but can be obtained from the authors upon request. The Composite Abuse Scale and Physician Readiness to Manage Intimate Partner Violence Survey are publicly available.

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5.3 MANUSCRIPT SUMMARY

This manuscript presented findings about the clinical impacts of DFV against health professional women. The results suggest that survivor health professionals may be doing more of the work regarded as good practice than their non-abused peers. Before adjusting for potentially confounding variables in the analysis, DFV exposure was found to be associated with nearly all aspects of clinical care. After adjustment, some of that effect did not remain, having been explained by the influence of DFV training, which was significantly associated with having a history of DFV. However, being a survivor health professional continued to be significantly associated with the uptake of DFV training, holding more sensitive attitudes about survivors, and having more frequently accessed DFV information to provide survivor women. Additional results about the relationship between training and clinical care are included below.

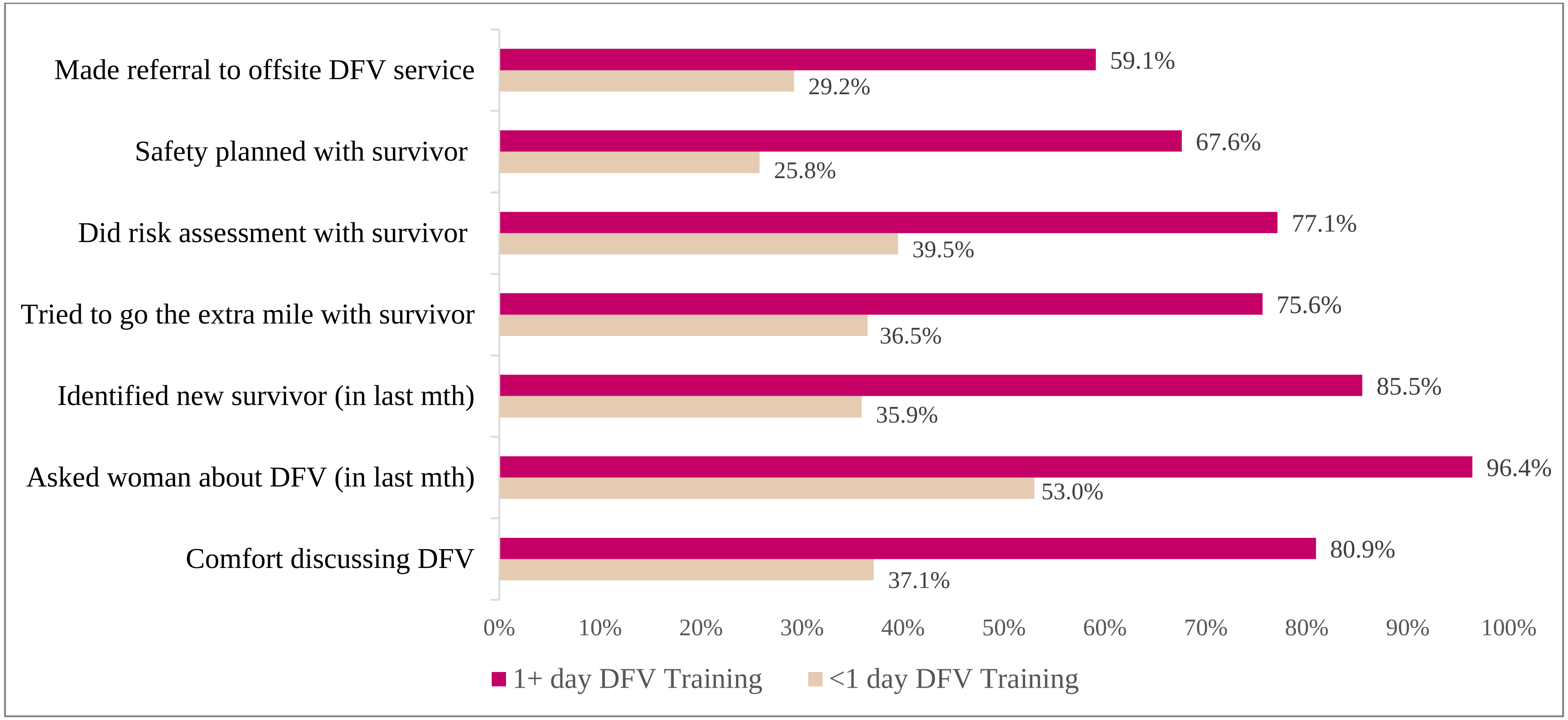
5.4 ADDITIONAL FINDINGS

5.4.1 The effect of DFV training on practice

Health professionals who had received one or more cumulative days of DFV training were more engaged in the provision of survivor care and response on every indicator compared to their peers without training, as demonstrated in Figure 13. For example, trained health professionals were more than seven times more likely than their peers to have asked patient/s about DFV in the last six months (adj OR 7.7, 95% CI 4.0-15.2). Further, the relationship between training and patient DFV enquiry appeared to be graded. Nearly all of the health professionals (96.5%, 82/85) who had completed more than eight hours of DFV training across their career had asked patients about DFV in the last six months. However, this had decreased to sixty percent (60.7%, 91/150) for those with less than four hours of training and only thirty-three percent (33.8%, 44/130) for health professionals who had never received DFV training. This training effect was observed despite the time or location of the training. Perhaps not surprisingly, being an allied health professional was also strongly associated with identification of new survivor patients in the previous six months (adj OR 5.8, 95% CI 2.8-11.8).

Figure 13. DFV training & survivor clinical care during the last 6-months

(n=471)



5.5 CONCLUSION

Together, the results of this second manuscript and additional results within this Chapter indicate that exposure to DFV is associated with clinical care provided by health professional women. Specifically, being a survivor health professional was associated with greater readiness for practice through having attended DFV training, holding more sensitive attitudes about survivors and having accessed more DFV information to give to patients in the last six months. The evidence advances that DFV does not appear to be a barrier to DFV patient care and it may even act as a facilitator. The results demonstrate a strongly positive, graded relationship between DFV training and the provision of survivor clinical care, irrespective of whether a health professional has experienced DFV. The next Results Chapter will report findings in response to the final two research questions of this thesis about the role of the hospital workplace in responding to staff survivors. In this final Results Chapter, the voices, perspectives and experiences of survivor health professionals and their managers are heard.

6.

Hospital workplace responses study

"[I want] *understanding if* [I'm] *not firing on all cylinders at work sometimes & ask to leave work early, be allowed without explanations when dealing with violence. It can be embarrassing & you don't want your workplace to know."*

(Survivor health professional participant)

"Every organisation I've ever worked in has always been about the patients' experience and not about people in the workforce. So, I can't imagine that it [better responding to survivor staff] *wouldn't require a cultural shift… I think that it needs to be explicit within occupational health and safety discussions - whether it's policies, procedures, et cetera."*

(Hospital manager participant)

6.1 OVERVIEW

This third and final Results Chapter is a qualitative study with survivor health professionals and hospital managers about the role of the hospital workplace in supporting survivor staff. Within this study, open-ended survey responses from 93 survivor staff and key stakeholder interviews with 18 managers were analysed thematically to find answers to research questions three and four of this PhD: *What support needs do survivor health professionals have of their hospital workplace?* and, *What are the views of key stakeholders about the role of the workplace in responding to staff survivors of DFV?* The findings were peer-reviewed and published in the Journal of Gender-Based Violence in July 2020. Consistent with the previous two results manuscripts, as the lead author, I wrote 90% or more of this paper, with important contributions on all aspects of its content from my co-author supervisors. All authors read and approved the final manuscript prior to submission. This Chapter concludes with a summary of the key findings and some additional findings about the perceived helpfulness of workplace supports including leave and training for key individuals.

6.2 PUBLISHED RESULTS MANUSCRIPT (PAPER 3)

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article

Hospital responses to staff who have experienced domestic and family violence: a qualitative study with survivor staff and hospital managers

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Health professionals play a critical role in responding to the health consequences of domestic and family violence (DFV). However, health professional women themselves experience high rates of DFV and there is scant evidence underpinning hospital workplace responses. The aim of this Australian research was to explore the views of survivor health professional women and their managers about the role of the hospital workplace in responding to survivor staff. A 'combined methodological approach' encompassed open-ended survey questions to survivor health professionals about workplace experiences and support needs. Managers participated in an interview about the employment response. Thematic analysis of survivor staff (*n*=93) and manager (*n*=18) data identified three themes: (a) *Understand that DFV affects staff*, (b) *Support for staff is essential* and (c) *Challenges of establishing a safe workplace*. Survivors wanted understanding about how trauma had affected them, and managers recognised that staff were exposed to potentially triggering patient narratives of abuse. Both groups believed that formal resources and support were essential, including managers trained to respond sensitively to disclosures of DFV. However, challenges to creating an environment where staff felt emotionally and physically safe were identified. A trauma and violence informed hospital response could promote recovery for survivor staff *and* patients.

Key words intimate partner violence • domestic violence • hospitals • health professionals • managers

Key messages

- A supportive hospital organisational response to survivor staff has three main components: (1) awareness-raising and understanding that domestic and family violence (DFV) affects staff at hospitals, not just their patients; (2) multifaceted support that is not disclosure dependent; and (3) promotion of staff safety.
- Developing a trauma and violence informed culture towards both hospital patients and staff could provide the infrastructure for a safe and supportive workplace response to staff DFV.

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Background

Prevalence and impact of domestic and family violence for health professionals

Domestic and family violence (DFV) is a common and chronic issue affecting Australian women, with health consequences leading to an over representation of survivors attending hospital services, who have mostly female staff (Campbell, 2002; Australian Bureau of Statistics, 2016). DFV is defined by the World Health Organization as 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship' (Krug et al, 2002). DFV abusive behaviours may be perpetrated by a partner or family member, and one such behaviour is child witnessing (World Health Organization, 2012). The term 'survivor' refers to someone who has experienced DFV (Elliott et al, 2005). This term is used in recognition of the strength and resilience of people with lived experience of DFV (Bond et al, 2018). Globally, 30% of women are affected; while the national Australian prevalence is 25% (García-Moreno et al, 2005; Cox, 2012). Women experiencing DFV access healthcare services more frequently than women without a history of DFV, and best practice with survivors includes a multifaceted bio-psychosocial response (Rivas et al, 2015).

Health professionals are increasingly recognised as being at the frontline of responding to violence and trauma in the family (García-Moreno et al, 2015). A recent Australian study found the lifetime prevalence of DFV against a group of 471 women nurses, doctors and allied health professionals was 45.3%; higher than the prevalence in the general community, while lower than in a clinical sample of women accessing primary care (McLindon et al, 2018). Some research has suggested that personal exposure to DFV may affect health professionals' readiness for DFV clinical care with survivor patients, acting as a barrier for some survivor staff and an enabler and motivator for others (Mezey et al, 2003; Beynon et al, 2012). An analysis of the association between health professionals' personal experiences of DFV and their clinical care of survivor patients found that survivor health professionals were more likely than their non-abused peers to have accessed professional DFV training, hold more sensitive and informed attitudes about DFV survivors and to have recently provided DFV information to their patients (McLindon et al, 2019). However, while DFV may be an enabler of good clinical practice, there are other impacts for survivor health professionals at work, including the risk of vicarious trauma from bearing witness to the traumatic narratives of patients (McCann and Pearlman, 1990; Gates and Gillespie, 2008; Goldblatt, 2009).

Employment and workplace support for survivors

Although employment can be an asset for survivors, DFV can negatively impact upon it and there is limited research about how survivor employees want their workplace to support them. While employment may afford social support, financial resources and increased exit options out of violence (Falk et al, 2001; Rothman et al, 2007; Blustein, 2008; Felblinger and Gates, 2008; Pollack et al, 2010), DFV can also contribute to job instability and problems at work which are, in turn, associated with depression and anxiety (Adams et al, 2013).

Research suggests that employers may have limited awareness about DFV experienced by employees, despite there being substantial costs to the organisation (Commonwealth of Australia, 2009). Mismatches between the type of support survivor employees want from their workplace, and that which they actually receive, are common (Swanberg et al, 2005; Swanberg et al, 2007; Yragui et al, 2012; Laharnar et al, 2015; Glass et al, 2016). Of the research about how workplaces can support survivor staff, most has focused on the perceived helpfulness of support and resources offered after disclosure, with mixed results (Samuel et al, 2011; Yragui et al, 2012; Laharnar et al, 2015; Glass et al, 2016; Kulkarni and Ross, 2016; MacGregor et al, 2016). In their Canadian study of 2,831 survivors (mostly employed in education), MacGregor et al (2016) found that survivors who had disclosed DFV generally perceived the support they had received as helpful, particularly having a 'listening ear', paid time off, assistance with safety planning and referral. By contrast, Kulkarni and Ross (2016) in their United States study of 500 employees in private business found that survivor employees perceived the workplace as less supportive and accommodating regarding DFV than did their non-abused peers.

How do hospitals respond to survivor staff?

Hospitals are unique workplaces since, in addition to survivor staff perhaps being overrepresented, they are often female-dominated, and the work of health professional employees necessarily exposes them to vicarious trauma and not uncommonly occupational violence from patients and visitors (Gates and Gillespie, 2008, Pich et al, 2017, Shakespeare-Finch and Daley, 2017, Shea et al, 2017). While all health professionals are at risk of vicarious trauma in their job identifying and responding to survivor patients, research suggests that vicarious trauma reactions may be heightened if the health professional has lived experience of DFV (McCann and Pearlman, 1990; Bell et al, 2003). As a site of employment, hospitals have not been investigated about their response to survivor staff (Garcîa-Moreno et al, 2015). An extensive review of the international literature located only one study with 3,611 health and education union members (response rate ~4.6%) (McFerran, 2011). The study investigated impacts and outcomes of discussing DFV at work for the 30% of survivors who had experienced lifetime DFV (5% in the last 12 months). Since the professional background of participants was not separated in the findings, the study does not provide specific outcomes for different employment settings. However, overall nearly half of the participants reported that DFV had sometimes affected their capacity to get to work, with 15% affected while at work (McFerran, 2011). Half (48%) of survivors had disclosed DFV to their supervisor, although only 10% found that helpful (McFerran, 2011). As a result of discussing DFV with someone at work, most survivors found that either nothing changed or the outcome was negative, with paid leave the main form of assistance offered (19%) (McFerran, 2011).

An additional gap in the literature is the hospital managers' views of their workplace's role in responding to employees who have experienced DFV. The authors were unable to locate any studies on this topic, despite some research in non-healthcare fields having previously identified the positive impact management can have in supporting staff (Swanberg et al, 2007; Glass et al, 2016; MacGregor et al, 2016). There would appear to be a gap in the literature about how hospital workplaces should respond to DFV affected employees from the perspectives of both survivor staff and hospital managers who administer and supervise hospital workplaces. To address this gap, the aim of this research was to explore: (i) *What support needs do survivor health professionals have of their hospital workplace?* and (ii) *What are the views of hospital managers about the role of the workplace in responding to staff survivors?*

Methods

This study utilised what Halcomb (2019) refers to as a 'combined approach' to research. This theoretical approach incorporates both quantitative and qualitative methods to collect data towards one aim. Using a combined methodological approach, qualitative and quantitative data were applied to answer different research questions. This was a large project about the prevalence (McLindon et al, 2018), impacts (McLindon et al, 2019) and implications of DFV against health professional women. Results of the quantitative data have been published elsewhere (McLindon et al, 2018; 2019). This article presents findings from the qualitative data about implications. Preliminary outcomes of the quantitative data with survivor health professionals formed the basis of the first interview question to managers and this was the extent of the interaction between the two data sets until the analysis phase (McLindon et al, 2018).

Study design, setting and participants

Qualitative survey data from survivor health professionals

Health professionals at a major Australian tertiary maternity hospital participated in a questionnaire about DFV prevalence, impacts and experiences at their workplace (McLindon et al, 2018; 2019). This hospital was selected as the research site as the first author was employed as a health professional there and the hospital fully supported staff participation in the study. The hospital was engaged in strengthening their response towards survivor patients, however, it had not begun addressing the issue of survivor staff. Methods are described elsewhere (McLindon et al, 2018; 2019). Briefly, an electronic and paper cross-sectional survey of all clinical health professionals was conducted between August and December 2013 (McLindon et al, 2018). The survey was developed by a team of DFV clinicians and researchers and it went through a pilot phase with health professionals, including survivors. Staff survivors were female nurses, midwives, doctors and allied health professionals who had experienced DFV and were employed in a maternity hospital setting. DFV victimisation included: self-reported family violence during childhood and/or 12-month or intimate partner violence since the age of sixteen measured using the Composite Abuse Scale (Hegarty and Bush, 2002; McLindon et al, 2018). This article reports the qualitative data from open-ended survey questions about the role of the hospital workplace. A survey method was chosen, rather than an alternative (for example, interviews, focus groups), because of the sensitive nature of the research topic (Braun and Clark, 2013). It was theorised that an anonymous survey would likely result in more comfortable and candid participation and a broader range of views (Braun and Clark, 2013). Staff survivor participants are identified via a number within the results.

Interviews with hospital managers

Face-to-face individual and group interviews were conducted with individuals in a position of leadership either at the hospital, an employee assistance programme (EAP) or union (hereafter uniformly referred to as 'managers') between April and June 2014. Group interviews were offered to employees in the same team, for example, human resources (HR) and the EAP. Recruitment was based on purposive sampling to obtain a wide range of views so that individuals at different levels of management and across every department at the hospital were represented. Eighteen managers participated in an individual or group interview (11 individual, seven in one of two group interviews). Interviews began with the interviewer providing a brief summary of the results of a prior DFV prevalence study, which showed that DFV commonly affected health professionals (McLindon et al, 2018). Managers were then asked what they thought the role of a hospital workplace should be in responding to staff survivors. The interviews were semi-structured, and open-ended questions explored what the hospital workplace was doing well/could improve on and the components of an effective response, including a case example prompt. Individual and group interviews lasted between 30 minutes to an hour in length and were audio recorded with consent before being transcribed verbatim and imported into NVivo (Version 11) (QSR International Pty Ltd, 2018). Manager participants are identified via a pseudonym within the results.

Data analysis

Data was analysed following the phases of thematic analysis specified by Braun and Clarke (2006). EM became familiar with the data, generating initial codes from the staff survivor and manager data separately, followed by open coding to generate concepts for both groups. While a coding frame was not used, EM, CH and KH were involved in double coding extracts of data in an active and reflexive process, reflecting those who were involved (Clarke and Braun, 2014). From here, the strategy for analysis varied based on the different methods of data collection.

Responses to open-ended questions by staff survivors ranged from a short sentence to several paragraphs in length, thus in-depth analysis was not always possible and the coding strategy was, in that case, predominantly descriptive (Braun and Clark, 2013; Kulkarni and Ross, 2016). For the manager interview data, a more detailed analysis could occur, and after creating a coding scheme, an inductive approach was undertaken to explore themes, engendering meaning and implications. Upon conclusion of the separate analysis of the two sets of data, the themes and subthemes were brought together to understand connections and distinctions between them. An iterative process with all authors ensued; the themes were checked to understand their fit with the coded extracts and the entire data set, developing a thematic map. In keeping with a common convention when representing prevalence in thematic analysis, a quantified measure (that is, an exact number) of the staff survivor and manager participants who contributed to a particular theme is not provided (Braun and Clarke, 2006). Rather, the proportion is indicated where it is deemed helpful for the reader. The data presented in this article was selected from the original sample to illustrate a theme, and to ensure quotes represented different participants. To limit the potential for bias in the selection of data for presentation, EM critically examined the perspective she brought to data analysis and met with CH and KH to review and agree (Critical Appraisal Skills Programme, 2018). EM, CH and KH agreed on the distinctions between each theme and reviewed the overall narrative of the analysis. Finally, all authors were involved in naming each theme (Braun and Clarke, 2006).

Ethics approval

Ethics approval was granted by both the recruiting hospital and the university Human Research and Ethics Committees (Ethics ID: 1339986).

Results

Survivor health professional characteristics

There were 471 health professional women employed at the tertiary hospital who participated in the survey, and of these, 212 (45.2%) had experienced DFV (McLindon et al, 2018). Of the survivor health professionals, 93 (43.8%) answered one or more of the open-ended survey questions about their workplace support needs. These responses are the focus of this article. Most of the staff survivors were nurse or midwives (63/93, 67.7%), aged between 30 and 59 years (80/93, 86.0%), with ten or more years of professional experience (63/93, 73.1%). For nearly a quarter of the staff survivors (21/93, 22.6%), intimate partner violence was a current issue in their life (last 12 months), and a third (29/93, 31.2%) had a history of multiple relationships where violence had occurred, self-reporting *both* intimate partner and family violence. Staff survivors described a range of DFV impacts on their lifetime employment, the most common being a physical or psychological injury that had affected them at work (60.8%).

Manager characteristics

Eighteen managers (14 female and four male) participated in an individual (*n*=11) or group interview (*n*=7) about the role of the hospital workplace in responding to DFV in the lives of staff. All but two of the managers approached agreed to participate and interviewees represented ~40% of clinical managers at the hospital. Manager participants were employed in the role of 'manager', 'director' or 'executive' within the hospital (*n*=15), EAP (*n*=2), or union setting (*n*=1).

Three distinct themes were constructed from analysis of the survivor staff and manager participant data: (a) *Understand that DFV affects staff*, (b) *Support for staff is essential*, and (c) *Challenges of establishing a safe workplace*.

Understand that DFV affects staff

In this theme, staff survivors reflected upon some of the ways that DFV had affected them in their professional role, and managers shared their perception of the challenges for survivors in the workplace. Some staff survivors described having felt alone in their experience of DFV and thought that breaking the silence and acknowledging that DFV affects health professionals, not just their patients, might send a message of support and hope against shame to other survivors. One survivor nurse suggested that she would support a survivor colleague by, 'reminding them that what they are experiencing doesn't make them an outcast and there are others out there who may be going through the same thing' (Staff Survivor 505). Speaking about awareness raising throughout her hospital, a survivor nurse said:

> I would like to see more openness about the number of current staff impacted by violence as I believe that would go some way to dispel many of the myths of family violence, e.g. it doesn't happen, if it was me I would just leave etc. It is so much more complex than that!! (Staff Survivor 521)

Unknowingly affirming the staff survivors who had made the same suggestion before them, some managers also spoke about building awareness that DFV affects staff in the hospital. These managers thought this was critical step towards encouraging survivors to seek support:

> It's a topic that has a perceived stigma attached […] if there were a few staff with the courage to start to disclose that could be a really powerful impact and help create awareness that it's okay to seek support. (Carol)

Staff survivors spoke about the impact DFV had had on their professional practice. Some credited it with improving their clinical skills, including motivating them to work 'with an understanding of trauma and its impact on people' (Staff Survivor 341). One staff survivor believed her experience gave her greater empathy for her colleagues experiencing diverse challenges:

> As someone who has experienced and survived domestic violence, I am actually very 'grateful' […] as I hope that it has given me a greater level of empathy for team members experiencing this or other challenges. (Staff Survivor 521)

More commonly however, survivors spoke about the difficult aspects of working within a hospital environment after DFV. This included being unable to function at normal capacity and finding aspects of the hospital environment a trigger to feelings of distress. For example, an allied health professional experiencing current DFV spoke about acting self-protectively to avoid traumatic memories being triggered:

> [I want] Time to debrief after talking to a woman who has disclosed a domestic or sexual violence issue, so I am not left worrying about the person. I deliberately avoided a [DFV] work presentation, afraid of the issues it might bring up for me. I did not want to think about them, especially the worst domestic violence and sexual violence of past relationships and as a child. There would be no one to talk to if I did become upset so I'd probably have to bottle it up and this could exacerbate my depression. (Staff Survivor 258)

Most of the staff survivors wanted their workplace to be a more supportive, flexible and understanding environment, 'So [survivors] are not in fear of losing their jobs as a result of what they might be experiencing' (Staff Survivor 461). Staff survivors wanted, 'Understanding if not firing on all cylinders at work sometimes' (Staff Survivor

80), and policy which, 'acknowledges this experience for staff – an important step in recognising and validating experience' (Staff Survivor 341).

Some managers spoke about challenges which they anticipated survivors might experience in talking about DFV, including feeling ashamed, fear of people being judgemental, and negative ramifications caused by evaluations about a survivor's capacity to do their work. As one manager said,

> Doctors are often very reluctant to admit depression, anxiety […]there's a professional potential for impairment in their career progression because if they report mental health issues, then we may or may not be obliged to report them to [the Australian Health Practitioner Regulation Agency], and in turn, if they perceive that hanging over their heads they may decline reporting. (Paul)

The choice of doctors not to disclose psychological health issues at work because of concern about career impairment is likely to be felt more broadly, including by other health professionals. This worry could pose a significant risk to a workplace environment where survivors feel able to seek DFV support, such as leave for appointments and role flexibility, which could be critical to wellbeing and ongoing employment. This type of culture also risks perpetuating the confidentiality matters that staff survivors raised, presenting a barrier to DFV support even if it were made available.

Support for staff is essential

The majority of staff survivors and managers thought that hospitals should have a planned support response for staff with a history of, or current DFV. They suggested equipping managers to respond, providing access to people with whom survivors could talk, flexibility in the workplace, and resources including DFV leave. Most managers and survivors thought that an environment of understanding and acknowledgement of the importance of staff wellbeing and safety was critical. Managers thought that to realise this, cultural change would be required.

The first and second most frequently cited aspects of a supportive workplace response were encouraging managers, HR and EAP staff to respond to survivors in a compassionate, confidential and informed way, building a culture of understanding, empathy and awareness in the workplace:

> Training/appointment of managers who are understanding and skilled with this issue to make it easier for staff to approach managers for help and equip managers/staff to recognise signs of DFV. (Staff Survivor 73)

The importance that staff survivors placed on managers and other key professionals being skilled to respond to disclosures by staff was illustrated in the difference between how managers and staff survivors conceptualised DFV leave. While most managers believed that leave was an important resource (not available at the time of the research), more survivors than not identified unease about DFV leave. Survivor staff's primary concern was that to access leave would require disclosure to somebody in authority who might not respond with sensitivity and discretion. As one survivor midwife said:

> Extra leave for DFV would mean that work would become aware of a person's situation and that is most often the last thing a person wants. It's easier to call in sick with nil stigma associated with such leave. (Staff Survivor 257)

To advance a culture where the wellbeing of staff, not just patients, is considered critical, many managers and some staff survivors thought cultural change was required. It was suggested that this be underpinned by an 'ideological policy position higher than Human Resources' (Anthony), prioritised by leadership and expressed through policy. Some survivors and managers thought that the ethos against bringing personal issues into the workplace should be challenged. As Louise said:

> Every organisation I've ever worked in has always been about the patients' experience and not about people in the workforce. So, I can't imagine that it wouldn't require a cultural shift […] I think that it needs to be explicit within the occupational health and safety discussions – whether it's policies, procedures, et cetera.

Many staff survivors wanted counsellors and other professionals, rather than their managers, human resource staff or EAP staff made available to talk about DFV. Other onsite resources were advocated for, including supervision, mentors and people with whom to debrief. These resources were suggested to mediate against the secondary trauma faced by all health professionals, as well as the negative impacts for staff survivors that could be triggered by a patient's narrative of abuse: 'I have tried to bring this up with Human Resources on many occasions but have fallen on deaf ears. I believe we need to have on-site counsellors who we can speak with at a personal and professional level' (Staff Survivor 148). Managers, however, rarely suggested this type of support.

More than half of managers thought that they individually, and as an organisation, had a 'duty of care' (Sarah) to provide DFV specific support to staff. In referencing clinical care of survivor patients as core business for the hospital, some managers were concerned that staff who required workload flexibility, or needed time off, could not always be accommodated. Some managers spoke about the sensitive nature of discussing DFV and the magnitude of competing clinical and other demands which hospitals are tasked with addressing that would get in the way of meeting a survivors' needs. Other managers queried whether it was feasible or even necessary to single out DFV as a specific area of staff support, suggesting that it be incorporated into a broader staff wellbeing or mental health programme:

> Would we write a guideline for everything that could happen in someone's life or is it more about skilling our managers to be able to respond to whatever people might come to them with or disclose to them? (Carol)

While managers and staff survivors both believed in the importance of a sensitive workplace response, many staff survivors had had experiences at work that were not safe, and managers too, raised this as a significant challenge to establishing a DFV-supportive environment.

Challenges of establishing a safe workplace

In the two earlier themes survivors called for understanding and confidentiality, and managers suggested a more supportive response. However, this would seem to be dependent upon a workplace being safe. In this theme, challenges to establishing workplace safety were explored. Survivors and managers spoke about safety in a nuanced way: including the absence of workplace abuse and harassment the risk of secondary trauma and emotional safety to feel comfortable to disclose DFV.

More than half of the staff survivors reported that their hospital workplace had, at times, been made unsafe because of bullying or harassment by colleagues, or abuse from patients and hospital visitors. Speaking of having experienced multiple threats to her safety, one staff survivor said:

> I have been physically threatened with 'Cut my throat' and 'I'll follow you to your car'. I have been bitten; had a bedside table rammed into my back and been choked by patients […] I have been called all sorts of things […] I have been yelled at by partners of women because I asked questions and because of waiting periods, etc and I have been verbally abused and bullied by my colleagues. (Staff Survivor 148)

This survivor was experiencing current violence by an intimate partner and disclosed a history of family violence as a child. Another staff survivor expressed how workplace bullying can, 'trigger memories/situations of past domestic violence. At times this workplace is like being in a domestic violent relationship' (Staff Survivor 482). This survivor's experience was of her home life made unsafe because of violent behaviour, compounded by an abusive workplace environment. Speaking about the importance of safety, and acknowledging that people are affected by their experience, one manager said:

> I think every workplace has a duty of care to ensure that the workplace is safe. Any organisation's employees bring themselves to work with their total being and that includes what's happened in your personal life. This can impact you, your productivity, your relationships and your level of safety in the workplace. (Judy)

Some managers referred to secondary DFV exposure through survivor patients, which one manager termed 'double jeopardy' (Helen). These managers identified hospitals as unique and potentially triggering workplaces where staff are routinely exposed to secondary DFV in their patients' lives when assessing a patient's history or providing clinical interventions:

> We're a workplace that is going to expose people to patients who have experienced violence. In really plain terms – it's like an occupational hazard. It is a risk here and it might aggravate pre-existing issues […] [better responding to this] it's really important. (Carol)

Some managers suggested that DFV staff support should be a specific issue planned for by the hospital. More than a quarter of managers had professional experience of supporting staff survivors either as their manager or colleague. They spoke about bearing witness to the ways physical and psychological injuries can impact a survivor at work and acknowledged the importance of survivors' feeling secure in their employment, not just for financial stability, but as a safe environment outside their home: 'Work is a very important part of keeping that person functioning […]it's part of rehab, it's part of their self-respect, self-esteem, financial' (Michelle). Some managers emphasised that an understanding, supportive and safe working environment for staff may, in turn, impact the hospital environment for patients:

> We need the people in our workplace to feel that they can give the best of themselves, both for their own fulfilment, and for the welfare of the organisation, which is a proxy for the patients that we look after. (Anthony)

Discussion

This research contributes to a gap in the literature: how hospital employers can support staff survivors of DFV (MacGregor et al, 2016). Survivors and managers suggested that everyone in the organisation should understand that staff may be affected by DFV, onsite and external support was considered critical, and challenges (including emotional and physical safety) should be confronted. Three themes were created from the two different groups of participants, (a) *Understand that DFV affects staff*, (b) *Support for staff is essential*, and (c) *Challenges of establishing a safe workplace*.

Despite the managers not being aware of the themes raised by staff survivors at the outset of their interviews, their ideas were generally supportive of, and consistent with those of survivor staff. This finding differs from previous research that found employers and survivors to be mismatched on the topic of DFV support needs (Yragui et al, 2012). The two areas where survivors and managers were most aligned were: suggestions for how the workplace could support survivor staff, and the importance of ensuring a safe workplace. This topic is important to mitigate the risk of a disparity between the type of support which survivors identify they need from their workplace and that which they are actually offered. Research suggests that this could be a vital component of trauma recovery (Pollack et al, 2010; Yragui et al, 2012).

Our findings confirm previous research regarding how employers can show support to staff survivors, including through schedule flexibility (Swanberg et al, 2007; Glass et al, 2016), workplace policies (Glass et al, 2016), the availability of someone with whom to talk (Kulkarni and Ross, 2016), raising awareness about staff survivors in the workplace (Glass et al, 2016), and working to dispel fear of negative outcomes in response to disclosure (Laharnar et al, 2015). The managers in our study cited DFV leave as a critical aspect of workplace support. Many survivors, however, expressed concerns about confidentiality and how they would be responded to if leave was disclosure dependent. These findings sit alongside those of McFerran (2011) who found that for participants who had disclosed their most recent episode of DFV to someone at work, the most common assistance offered was paid leave which was often not the only type of support that a survivor needed. The remaining participants in that study named privacy concerns as their chief reason for not disclosing DFV at work (McFerran, 2011).

More than half of the survivors in our study had felt unsafe in their workplace because of harassment by colleagues and a culture of silence about mental health problems highlighting the challenge to establishing workplace support for DFV.

Beyond the struggle of gathering commitment and resources from within an organisation, cultural issues can pose barriers to employees feeling safe to access DFV support (British Medical Association, 2019).

The location of the survivors' employment was not incidental in this study. Hospitals are critical sites for research on this topic because in addition to the risk of being a primary survivor of DFV, all health professionals' work exposes them to secondary trauma (Sinclair et al, 2017). The survivors in this study were all working in an environment where they were identifying and responding to violence against predominantly pregnant women and their children; emotionally demanding work that was emphasised by several participants (Mollart et al, 2009). Health professionals routinely hear the traumatic stories of patients (Gates and Gillespie, 2008). Over time, this can result in a secondary or vicarious trauma response (McCann and Pearlman, 1990). The term 'vicarious trauma' describes the accumulation of stress or problematic reactions experienced by clinicians, researchers and others who witness to other people's stories and images of abuse (McCann and Pearlman, 1990; Kulkarni et al, 2013). This type of a reaction may be hastened or heightened if the health professional has their own trauma history, which is not uncommon (Jenkins et al, 2011; Newcomb et al, 2015). Additionally, health professionals face a daily risk of abuse from their patients and harassment from their colleagues (Walsh, 2014; Shea et al, 2017). Although this study was limited in its focus to one hospital in Australia, these findings may contribute to wider efforts aimed at improving workplace support for hospital staff affected by DFV.

Limitations

One limitation of this study was the focus on a particular group of survivor employees (health professionals), and a specific type of workplace (a hospital), which may restrict the learnings being applied in other settings. Another limitation included the collection of qualitative data through open-ended survey questions which may have affected the depth of the survivor data. This study included two different participant groups, and two methods of data collection, which might be viewed by some as a limitation because of the potentially divergent paradigms and the risk of not attending enough to context (Barbour, 1998). However, method and data source triangulation can also contribute to deeper understanding because they arise from different perspectives, reinforming the study's thesis (Carter et al, 2014). Another strength was the health professional background of EM who administered the survey and conducted the interviews. As a hospital social worker employed at the research site, participants may have felt enhanced trust and exhibited greater openness (Braun and Clark, 2013). Finally, a strength of this study was the rigorous data analysis, which included investigator triangulation (Carter et al, 2014).

Summary and implications

The themes raised by survivor health professionals and their managers about how hospitals can respond to staff affected by DFV indicate the potential of a trauma and violence informed organisational approach towards patients *and* staff (Ponic et al, 2016). While trauma and violence informed practice has advanced strongly in relation to service users of mental health and human service systems in Australia (Quadara,

2015) and overseas (Hopper et al, 2010), to date it has not been conceptualised for general hospitals. A 'strengths-based' framework, trauma and violence informed care guides the organisation and behaviour of the entire system in which it is implemented, so that every interaction aims to promote recovery (Elliott et al, 2005; Hopper et al, 2010). Trauma and violence informed organisations understand the centralising influence that trauma can have in people's lives, prioritise psychological and physical safety, including through addressing secondary or vicarious trauma, and respond to the diverse and sometimes complex needs of survivors with a focus on rebuilding a sense of control (Harms, 2015). Developing a trauma and violence informed culture in hospitals may encourage a more empowering and health-promoting organisation for both health professional staff and their patients (Bloom, 1997; Cocozza et al, 2005).

Conflict of interest

The authors declare that they have no conflicts of interest.

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6.3 MANUSCRIPT SUMMARY

This manuscript presented the qualitative findings of open-ended survey questions with survivor health professionals employed at the tertiary maternity hospital and interviews with their hospital managers. Participant voices punctuated this paper, which is a good time to note that a list of participant pseudonyms for the quotes that open each of the thesis Chapters can be found in Appendix W. The research questions that the methods in this Chapter answered were about the role of the hospital workplace in responding to survivor staff. The results suggested three main approaches to a supportive organisational response: (1) it should raise awareness that DFV affects staff; (2) it should include multifaceted support not dependent on disclosure; and (3) it should address challenges to staff safety. It was concluded that developing a trauma and violence informed culture towards both hospital patients and staff could provide the infrastructure for such a workplace response. The final section of this Chapter presents additional findings about workplace support that the manuscript did not have the scope to include.

6.4 ADDITIONAL FINDINGS

6.4.1 The impacts of DFV at work

Survivor staff were asked about how DFV had impacted upon them at work, including being unable to get to work, reduced functioning while at work and abuse that had encroached upon the workplace. More than half of the survivor health professional women reported having experienced one or more negative impacts of IPV at work (Table 13). Nearly half (47.8%) of survivors who had experienced abuse by a partner or ex-partner during the last 12-months reported that they had been harassed or stalked at work sometime in the past. Half (54.3%) of the survivors whose partner’s abuse had occurred during the last 12-months reported that they had been impacted by a physical or psychological injury (including depression or anxiety) at some time during their career. 60.8% of survivors with lifetime IPV identified the same way. Finally, more than a quarter of survivors had needed to use unpaid or, more commonly, paid leave (i.e. sick or annual leave) because of IPV.

Table 13. Impacts of DFV in the workplace

Values are numbers (percentages) unless otherwise stated

Workplace impacts	**12-month IPV survivor health professionals** (*n*=46) [a]	**Adult lifetime IPV survivor health professionals** (*n*=125) [b]
One or more negative workplace impacts	27 (58.7)	84 (67.2)
Took paid/unpaid leave	12 (26.1)	26 (28.8)
Harassed or stalked while at work	22 (47.8)	32 (25.6)
Worked to avoid violence at home	4 (8.7)	16 (12.8)
Late to work or stopped from going to work	10 (21.7)	22 (17.6)
Work performance affected by emotional or physical injury	25 (54.3)	76 (60.8)

Notes

[a] Denominators vary due to missing responses. Higher numbers of missing respondents reflect the optional nature of the question: participants were only asked to select variables that reflected their experience. Maximum missing data *n*=4 (8.0%);

[b] Maximum missing data *n*=18 (12.3%)

6.4.2 Other workplace supports

In the cross-sectional survey, all health professional participants were asked their views about the perceived helpfulness of four different types of workplace support: paid and unpaid DFV leave and key individuals trained to sensitively respond to staff. None of these supports were available at the recruiting hospital at the time of the research. Table 14 presents these results.

Table 14. Perceived helpfulness of types of employment support

Values are numbers (percentages) unless otherwise stated

Employment supports perceived as h*elpful/very helpful*	**All health professionals (*n*=464)**	**Health professional survivors of lifetime DFV (*n*=211)**
Special/additional DFV leave	292 (62.9)	135 (65.9)
DFV leave within current leave entitlements	175 (38.1)	77 (37.4)
Trained Employee Assistance Program counsellors	393 (85.2)	181 (86.6)
Trained hospital managers	388 (83.4)	181 (85.4)

The results indicate that staff survivors and their non-abused peers had very similar views about the helpfulness of these four types of support. Across both groups, nearly double the number of staff thought that paid DFV leave would be helpful compared to DFV leave within current leave entitlements. Overall, however, the results suggest some ambivalence about DFV leave, since only just over half of the staff rated paid leave as helpful. Some of this ambivalence was clarified in the open-ended survey comments, of which several specifically pertained to DFV leave. As one staff survivor said about why said she would not access DFV leave, "*I would be concerned about confidentiality*" (Staff survivor 266). There was much more agreement about the helpfulness of key individuals internal and external to the hospital being trained to respond sensitively to staff DFV disclosures. The provision of DFV training to employees who provide supervision and support (e.g. hospital managers, Employee Assistance Program staff), could augment a hospital response where survivor staff are believed and supported regarding the impact of DFV, including at work.

6.5 CONCLUSION

In this Chapter, to answer research questions three and four, survivor staff and hospital managers were asked about the role that the hospital workplace could and should play in the support of staff who have experienced DFV. The open-ended survey responses from survivor staff and interviews with managers suggested that the views of the two groups were largely aligned. Their views could be encompassed in three words: understanding, support and safety. Staff survivors wanted their hospital workplace to understand that they, not just their patients, were survivors of DFV. Survivor staff spoke about having to act protectively at work because memories of abuse could be triggered in the course of routine care, and they spoke of their sensitivity and empathy for others related to experience. Extra analysis presented after the paper indicated some of the impact that IPV against health professionals had had at work beyond patient care. The majority of survivor health professionals had suffered challenging or harmful impacts of IPV at work, and partner stalking and harassment on the job had not been uncommon.

Survivors wanted a range of DFV resources housed within a supportive, understanding and flexible environment where they were not in fear of negative employment repercussions. While perhaps lukewarm about the helpfulness of DFV leave, they were clear about the benefit of sensitively equipping key people to respond when a disclosure is made. Lastly, survivor staff wanted safety to be prioritised in the workplace more broadly: they sought to feel emotionally safe to disclose DFV and they wanted their workplace to prioritise physical safety from patient aggression and bullying from colleagues.

Through the interviews with hospital managers, many expressed surprise about the prevalence of DFV among staff and acknowledged a significant role that they believed should be assumed by the organisation in response. Some managers recognised the hospital as an environment that would necessarily remind staff of their own trauma because of disclosures by survivor patients. Managers thought that support, especially DFV leave, was an important component of a responsive system underpinned by policy and strengthened through training. Managers disagreed about whether cultural change was required for the organisation to better orient itself towards the emotional needs of staff. These findings suggest the components of a comprehensive workplace response towards survivor staff that is trauma and violence informed in theoretical approach - a framework which will be developed in the final Chapter of this thesis.

This concludes the presentation of findings in Part II of the thesis. In Part III, the final section of this thesis, all of the findings will be discussed in the context of the literature in Chapter 7, and the implications and conclusions explored in Chapter 8.

Part III

Discussion & Conclusions

7.

Discussion of Findings

"Sometimes we can take things home with us that we don't even realise and build up a hardness or sensitivity when we haven't been able to debrief about how responding to violence affects us personally."

(Survivor health professional participant)

"Of course, I would like managers to have the skills and the capacity and the empathy to deal with their colleagues in a caring, supportive way full stop."

(Hospital manager participant)

7.1 OVERVIEW

The context for this PhD is DFV in the lives of health professional women, the impact on readiness for clinical care with survivor patients, and how the hospital workplace can respond to survivor staff. This Discussion Chapter begins with a summary of the gap in the literature that it was the aim of this research to answer, followed by a restatement of the research questions and consideration of the key findings of the thesis. The Chapter then moves on to its main purpose: to consider the results of this thesis within the context of the broader literature, so that implications from the findings may be reached.

7.2 SUMMARY OF THE GAP IN THE LITERATURE

Hospitals and the health professionals who work within them are ideally positioned to respond to the health sequelae of DFV (García-Moreno et al., 2015). The emphasis for decades has rightly been on how health professionals can provide the best care to survivor patients (García-Moreno et al., 2015; Kalra, Di Tanna, & García-Moreno, 2017; Rivas et al., 2015). The multitude of potential barriers to health professional's clinical care of survivor patients includes time constraints, discomfort discussing DFV and, potentially, a personal history of DFV (Mezey et al., 2003; Sprague et al., 2012). Research has been quietly building to bring the clinician as the survivor into the frame (Bracken et al., 2010). As detailed earlier in this dissertation, most of the research about survivor health professionals has found that DFV prevalence broadly reflects that of the national population among whom clinician participants live (Al-Natour et al., 2014; Bracken et al., 2010; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Doyle et al., 1999; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). However, study limitations including measurements that lack rigour, small sample sizes, survivor participants with secondary, not primary DFV exposure, and low or unpublished response rates, make these studies difficult to generalise to an Australian context. It was clear there was a gap in the evidence about exposure to 12-month and lifetime DFV against female health professionals in Australia.

Beyond how common the experience of DFV is in the lives of health professional women, the resultant impacts on work at the frontline of responding to survivor patients emerged as unknown. A handful of studies had investigated the relationship between a health professionals' personal exposure to DFV and their clinical care of survivor patients

(Candib et al., 2012; Christofides & Silo, 2005; Rodriguez et al., 1999; Stenson & Heimer, 2008). The results, however, did not deliver clarity regarding whether survivors' clinical practice differed from that of non-survivors, since half found no association (Candib et al., 2012; Christofides & Silo, 2005), while those remaining found personal exposure was linked to improved DFV screening and patient follow-up (Rodriguez et al., 1999; Stenson & Heimer, 2008). These studies had methodological flaws, including not adjusting for likely confounding factors in their analysis. There was a need to clarify the association between health professional exposure to DFV and clinical care of survivor patients.

The context in which many health professionals work is a hospital setting. As an occupational industry employing thousands of health professionals in Australia alone, hospitals have had little attention paid to what, if any, infrastructure they have in place to support and respond sensitively to their survivor staff. In reviewing the evidence, no studies were found on this topic. Prior literature from other employment sectors had noted that, while employment can be negatively impacted by an employee's experience of DFV, there is simultaneous potential for survivors to be supported and resourced by their workplace toward greater safety and recovery (Swanberg & Logan, 2005; Swanberg et al., 2006). Survivors may be apprehensive about disclosing DFV at work, but workplace actions and resources including listening, paid leave, safety planning and referral, may be helpful (MacGregor, Wathen, & MacQuarrie, 2016). There is a risk of a support mismatch between the needs of survivors and the provisions assumed to be necessary by supervisors or managers (Yragui et al., 2012). Addressing the uncertainty about how hospitals can best support survivor staff was deemed critical to improving responses to survivor clinicians whose professional role places them at the frontline of helping others recover.

Re-statement of aims, research questions, methods & hypotheses

To address the identified gaps in the research, the aim of this PhD was to investigate the prevalence, impacts and implications of DFV against Australian health professional women. In response to this aim was four corresponding research questions:

1. *What is the prevalence of DFV and other interpersonal violence in an Australian health professional population?*

2. *Do health professional's personal experiences of DFV affect their DFV attitudes, comfort to discuss the issue with patients, enquiry, and response towards survivor women?*
3. *What support needs do survivor health professionals have of their hospital workplace?* and,
4. *What are the views of key stakeholders about the role of the workplace in responding to staff survivors of DFV?*

To address the aim and answer the research questions, a "combined approach" method was employed for this thesis (Halcomb, 2019). An electronic and paper cross-sectional survey about the prevalence, impact and implications of DFV in health professionals' personal lives was completed by 471 health professional women (67.5% nurses and midwives, 14.7% medical and 13.0% allied health). This represented a 45.0% response rate. Open-ended survey responses were provided by 93 survivor health professional women. Individual and group interviews were conducted with 18 key stakeholders - organisational leaders (directors and managers) with responsibility for administrating, supervising and supporting staff at the tertiary hospital workplace where the survey took place. Interviewees represented ~40% of clinical managers at the hospital. Five hypotheses were postulated for research question two. It was hypothesised that survivor health professionals compared to their non-survivor peers would: 1) demonstrate more sensitive attitudes towards survivors; 2) feel more comfortable discussing DFV and sexual assault with their patients; 3) ask more patients about DFV; 4) identify more survivors within a six-month period; and, 5) provide more DFV interventions to survivor patients, including referral.

7.3 INTRODUCTION TO THE KEY FINDINGS OF THE RESEARCH

Three key findings resulted from this thesis and they represent a distinct contribution of new knowledge to the field of DFV against health professional women. Firstly, DFV was found to be common in the lives of Australian health professional women (McLindon et al., 2018). Secondly, health professionals' exposure to DFV was associated with aspects of improved clinical care of survivors, including enhanced preparedness and responses after patient disclosure (McLindon et al., 2019). However, the impacts of DFV had frequently affected survivor health professionals at work and had at times contributed to reduced functioning. Thirdly, hospital workplaces were found to have a critical role in supporting and resourcing survivor staff within an environment of understanding, confidentiality and safety (McLindon et al., 2020). Survivor health professionals wanted hospitals to realise and respond to that critical role, and key stakeholders believed that it was part of the core business of a hospital workplace.

7.4 THE PREVALENCE OF DFV

The first key finding of this thesis was that DFV appeared to be common in the lives of health professional women. Prevalence among the clinicians in this study was indicated to be similar or higher than the general population (McLindon et al., 2018). The results revealed that 12-month IPV had affected one in ten (11.5%) clinicians, while IPV recalled since the age of sixteen had been perpetrated against a third (33.6%) of health professional women.

Locating these findings within a national context, 12-month IPV against the health professionals in this study may have been double or more than that reported in the broader Australian community (Cox, 2015). For example, physical and sexual IPV had been experienced by 4.8% of women in this study, compared to 2.1% of the 17,000 Australians who took part in the Australian Bureau of Statistics, Personal Safety Survey (Cox, 2015). The indication of a higher burden of IPV against health professionals is reinforced by a survey of 3,611 unionised professionals in Australia, where the 12-month IPV prevalence of all types of IPV (5.0%) was half that of the participants in the present study (McFerran, 2011).

Compared to a clinical study of patients attending a primary care clinic, IPV during the past year was lower among the health professional women in this study using the same CAS measure (19.6%, N=1,344) (Hegarty & Bush, 2002). This would appear to validate the findings of the present research because it could be expected that 12-month IPV exposure would be lower in a sample of currently employed hospital clinicians compared to a sample of patients presenting to a primary care doctor with clinical symptoms of poor health (Hegarty & Bush, 2002). This is reinforced by evidence that DFV is consistently higher among those seeking health care, including primary care (Hegarty, 2006; World Health Organization, 2013).

Moving beyond the last 12-months, to recall of IPV throughout the adult lifetime, prevalence reported by the health professionals in this study was again similar or higher than has been reported in the community (Australian Bureau of Statistics, 2017; Australian Institute of Health and Welfare, 2018), and clinically (Hegarty & Bush, 2002). For example, among the participants in this study, a quarter (25.6%) of participants had experienced fear of a partner, which is similar to the clinical primary care sample discussed above, where the lifetime fear of a partner was 28% (Hegarty & Bush, 2002). The adult lifetime incidence of intimate partner rape or attempted rape was reported two to three times (12.1%) more commonly by the health professional women in this study compared to the general population (4.7%) (Australian Institute of Health and Welfare, 2018), including in a large community sample that used the CAS (Holden et al., 2013).

Importantly, the Personal Safety Survey (PSS) (Cox, 2012) and Union surveys (McFerran, 2011) cited above, used different survey measures to establish community prevalence than were used in this study. While other studies can be an important indication of context, they do not provide a direct comparison with this study. Apart from content and length differences, other differences between the CAS and the PSS include the definition of partner (PSS: cohabitating intimate partner / CAS: person with whom you have been in a relationship for six or more months) and the onset of adulthood (PSS: 15 years / CAS: 16 years) (Australian Bureau of Statistics, 2017; Hegarty et al., 2005). As previously mentioned, the Union survey differed from the CAS by only asking one item about the experience of “domestic violence” in the last 12-months or longer ago (Hegarty et al., 2005; McFerran, 2011).

Including family (of origin) violence, 45.2% of health professional women had experienced either violence from a partner or family member, with 12.8% having experienced both. Lived experience of violence or abuse by a family member in childhood more than doubled the likelihood that a participant would report IPV as an adult. Of two international studies that report childhood witnessing of parental IPV, the prevalence among the health professionals in this study appeared to be three times higher than that reported in a Swedish study by Stenson and Heimer (2008) of 588 nurses, while similar to a USA study of 400 physicians by Rodriguez et al. (1999).

Nearly one in five health professional women reported that they had experienced other interpersonal violence or abuse outside the home. Most of this violence was also gendered, with the majority of perpetrators identified as men known to the survivor: their friends, patients and colleagues. Only a small proportion (5.6%) of participant survivors of violence or abuse outside the home had experienced this type of violence alone. The odds that a health professional had been abused outside their home were significantly greater for DFV survivors. With the inclusion of ‘other’ violence, the overall group of health professional women who had been exposed to some kind of interpersonal violence or abuse (perpetrated by either a partner, family member or somebody else) increased to half (50.8%) of all women in the study. Again, these findings are difficult to place in a broader context because of differences in the measures used, however they indicate a substantial burden of violent and abusive lived experience in the homes of Australian health professional women.

7.4.1 Impact of DFV at work

Beyond the commonality of DFV trauma in the lives of health professional women, many staff survivors also shared their experience of being impacted by DFV while at work. More than one in two survivor participants had felt unwell, tired, distracted, been injured, anxious or depressed at work because of DFV. Just shy of half of those survivors whose DFV had occurred in last 12-months said that they had been stalked or harassed while at work. Using paid or unpaid leave had also been required for between a quarter and a third of survivors. This was in the days before DFV leave had been secured for health professionals in Victoria. These results corroborate the findings of a great deal of previous work about the impacts of IPV on employment (Crowne et al., 2011; La Flair, Bradshaw, & Campbell, 2012; Logan, Shannon, Cole, & Swanberg, 2007; MacGregor, Wathen, Olszowy, et al., 2016; Rayner-Thomas, Dixon, Fanslow, & Tse, 2016; Rayner-Thomas et al., 2014; Swanberg et al., 2005; Swanberg et al., 2006), including those of McFerran (2011) on which the present study’s questions about workplace impacts were based.

The present study is novel through the contribution it makes to the evidence about a group of survivors that have received little attention about their employment experience to date. Much, although by no means all, of the research on DFV and employment has been with low-income and unskilled working women, often in the USA (Browne & Salomon, 1999; Brush, 2000; Crowne et al., 2011; Lloyd, 1997; Logan et al., 2007; Tolman & Wang, 2005). The next part of this Chapter explores whether experiences of DFV trauma may be consciously or unconsciously linked with the desire to help or care for others. Prompted by these thesis findings, this topic deserves further exploration.

7.4.2 The 'wounded healer'...or not?

As it became clear that the DFV trauma load was substantial for many health professional participants in this study, the question arose: has a high trauma load been observed in other related fields? Reviewing the literature yielded a body of work about the over-representation of people who work in mental health, counselling, social work and related therapeutic fields (*'helping professionals'*) who themselves have traumatic histories (Butler, Maguin, & Carello, 2018; Elliott & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Jenkins et al., 2011; Kinman & Grant, 2011; Newcomb et al., 2015). For example, a recent study of the number of Adverse Childhood Experiences (ACEs) reported by 195 social work graduates found that three quarters of those graduates had experienced three or more ACEs (out of a maximum 10), while a third reported four (Butler et al., 2018). Compare this with a population study (*N*=13,494) that found only 6.2% of people reported four or more adverse childhood exposures (Felitti et al., 1998). Exposure to four or more adverse childhood experiences is associated with a four to twelve-fold increase in serious physical and psychological health issues (Felitti et al., 2019). Research with helping professionals has relevance for the current study because, like helping professionals, the health professional participants in this study indicated a higher DFV burden than members of the general community. Further, allied health professionals (e.g. social workers) stood out as survivors of family of origin violence and it is their job to provide specialist DFV patient support in hospitals (State of Victoria, 2014-16).

The present study indicates that the trauma load for health professional women, even before they enter the workplace at the start of a shift, is substantial. That load is overwhelmingly perpetrated by partners and family members. These findings suggested a life course effect and are consistent with evidence about the cumulative risk of violence and adults being more at risk of DFV by their partner if they were exposed as a child (Australian Institute of Health and Welfare, 2018). Add to this that the hospital environment can be harmful or even dangerous, with bullying and aggression from patients, visitors, and colleagues, sadly not uncommon (García-Moreno, 2002; Level Medicine, 2019; Pich et al., 2017). Prior literature suggests that survivors of three or more forms of violence have a four-fold increased likelihood of poor psychological health compared to those who experience one form (Rees et al., 2011; Simmons et al., 2015). It may be useful for hospitals to understand the potential trauma load that health professionals carry into their work. This is a load which gets added to during routine clinical care for patients, through exposure to secondary or vicarious trauma.

The next question prompted by these findings was whether there is something about the experience of DFV that is associated with wanting to help and care for patients in health settings? What emerged from the literature was the idea that a possible impact of DFV may be the conscious or unconscious desire of some survivors to want to help others, also referred to as the ‘wounded healer’ (Jung, 1961). First theorised by Jung (1961), in his construction, wounded healers were trauma survivors that had transformed or transcended their experience of adversity into greater empathy and an enhanced capacity to heal others (Newcomb et al., 2015). Emerging from studies about the impact of childhood trauma and adversity, several possible explanations for the wounded healer have been posited (Elliott & Guy, 1993; Farber, Manevich, Metzger, & Saypol, 2005; Jenkins et al., 2011; Newcomb et al., 2015). These include that survivors might have an over-developed sense of empathy attracting them to the helping professions; they may be motivated to transform their personal learnings for good, including through having undergone a conscious self-reflective process leading to an enlightened understanding of the experience of trauma and adversity (Farber et al., 2005; Jung, 1961; Newcomb et al., 2015). Further theories are that survivors might seek personal address of their trauma by supporting others, or, they may just be better at identifying childhood experiences as traumatic (Elliott & Guy, 1993; Farber et al., 2005; Jenkins et al., 2011).

Enhanced empathy & ability to cope with stress

In a study of 101 sexual assault and domestic violence counsellors about their motivations for entering the profession, counsellors who had experienced childhood trauma linked this with greater empathy and desire to help others (altruism) and to apply the learnings of their experience (Jenkins et al., 2011). While the researchers had hypothesised, based on previous research (Pearlman & Macian, 1995), that survivor counsellors would report negative changes in themselves as a result of their trauma work with clients, they found the opposite (Jenkins et al., 2011). This and other studies have found that survivor counsellors often report positive impacts from their work with survivor clients, including increased or different meaning in their own lives, and an enhanced adaption to stress (Elliott & Guy, 1993; Kinman & Grant, 2011; Newcomb et al., 2015), also referred to as "stress inoculation" (Jenkins et al., 2011, p. 2393). These positive impacts have been conceptualised as a type of resilience that is constructed multi-dimensionally, including through the successful address and integration of trauma, as well as via learnings gleaned from clients (Jenkins et al., 2011; Jung, 1961; Kinman & Grant, 2011; Newcomb et al., 2015; Rajan-Rankin, 2014). This characterisation challenges the view that trauma is an inevitable and enduring vulnerability or therapeutic liability that necessarily results in ongoing disruptive and painful impacts, burnout or the negative countertransference of unmet need onto others (Boscarino, Figley, & Adams, 2004; Jenkins et al., 2011; Newcomb et al., 2015). Posttraumatic growth and resilience in the aftermath of trauma will be explored further in this Chapter.

Better recognition of the past as traumatic

Research has found that helping professionals may be more able than others to recognise their past experiences as traumatic (Elliott & Guy, 1993; Newcomb et al., 2015). This could be due to voluntary or professionally required counselling that helping professionals have participated in themselves (Elliott & Guy, 1993; Jung, 1961). It has been speculated that this process of self-reflection may begin in University and be continued through professional supervision for clinicians such as social workers, where it is a common occupational requirement (Kinman & Grant, 2011; Newcomb et al., 2015). Partaking in therapeutic counselling in the course of professional practice may also explain the finding among a sample of 2,963 professional women that unexpectedly showed survivor mental health professionals' psychological functioning was far less impaired than childhood abuse survivors working in other fields (Elliott & Guy, 1993).

It is likely that those working in the helping professions are particularly aware of the prevalence of trauma and adversity in people’s lives given their training and professional experience. This raises a question about whether part of the wounded healer puzzle is that therapeutic or helping professionals experience less self-stigma in identifying their own history as traumatic. Helping professionals, especially those working in counselling, DFV and mental health, have a job that requires varying levels of education about DFV and discussions with clients and patients about violence and abuse (Gore & Black, 2009). It is the counsellors’ job to assist those with whom they are working to identify and understand their past adverse experiences through a trauma lens (Elliott & Guy, 1993). It might then follow that survivors in the helping professions experience less self-identification inhibition than other people, especially in the context of underreporting in the general community (Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001). In the current study, the nurses, doctors and social work participants have a job that necessitates frequent contact with survivor patients. Conversations with patients and clients about DFV, case consultation with colleagues, invitations to attend DFV training and reading DFV case notes, are all routine aspects of their health professional role. For allied health professionals, DFV clinical care occupies a greater proportion of their role than other health professionals. Perhaps the allied health professionals in this study were more willing to disclose personal exposure to DFV, hinting at the possibility of underreporting by other health professionals. Or perhaps allied health professionals did indeed have a higher prevalence of DFV, which makes sense particularly if a prior background of trauma commonly precedes entry to a therapeutic/helping profession.

The present study about the prevalence and impacts of DFV was not causative, nor does it seek to retrofit causation. The wounded healer literature provides a lens or framework through which to understand the increased prevalence of trauma and adversity that has been observed in the lives of helping professionals outside general health. The evidence canvassed was that trauma and its impact, both complex and diverse, can lead to an enhanced capacity to ‘heal’ and ‘help’ others, as well as to manage the difficulties and stresses of clinical work with survivors. An extension of this is research which has found that survivor helping professionals can demonstrate enhanced resilience to stress and appear less predisposed to vicarious trauma than those without lived experience (Elliott & Guy, 1993; Follette et al., 1994; Kinman & Grant, 2011). This is especially relevant background literature when considering the finding of this thesis that survivor health professionals appeared to engage in more DFV work than their non-victimised peers (McLindon et al., 2019). Others have speculated that perhaps survivors had found beneficial ways of coping linked to their helping professional field, including by highlighting the positive impacts and learnings from their clients (Elliott & Guy, 1993; Follette et al., 1994; Jenkins et al., 2011; Kinman & Grant, 2011). However, present in the wounded healer literature is the concurrent potential for survivor helping professionals to self-report higher symptoms of stress, burnout, vicarious trauma and secondary traumatic stress (Figley, 1995a; Jenkins et al., 2011; McCann & Pearlman, 1990; Newcomb et al., 2015; Pearlman & Macian, 1995), even though they may be able to better manage the impact of this stress compared with their non-victimised peers (Boscarino et al., 2004; Cunningham, 2003; Gore & Black, 2009; Jenkins et al., 2011; Pearlman & Macian, 1995). While it remains unclear if, or exactly how, a helping professional's own history of trauma is associated with secondary or vicarious trauma, vicarious trauma is an important consideration for anyone exposed to the trauma of others and will now be considered (Bell et al., 2003; McCann & Pearlman, 1990).

7.4.3 Vicarious trauma

Wounds can of course, stem from many causes. Hearing stories of abuse and trauma can expose the listener to their own experience of stress, which, over time, can become a wound called 'vicarious trauma' (McCann & Pearlman, 1990). All healthcare workers, not just those with their own history of adversity, can and likely will, over time be affected by hearing the traumatic stories of their patients and intervening at some of the most difficult and distressing points of life and death (Bell et al., 2003; Sinclair et al., 2017; Slade, Sheen, & Spiby, 2017). The impact of bearing witness to someone else's trauma increases with repeat exposure (Bell et al., 2003; McCann & Pearlman, 1990; Mollart et al., 2009). 'Compassion fatigue' (Figley, 1995b), 'burnout' (Maslach, 1993), and 'secondary traumatic stress' (Figley, 1995a) are similar concepts to vicarious trauma (McCann & Pearlman, 1990), differentially indicating the accumulation of stress or problematic reactions experienced by clinicians and researchers exposed to stories and images of abuse from those with whom they are working (Bell et al., 2003; Follette et al., 1994; Kulkarni et al., 2013). Research has found that even informal supporters of DFV survivors - friends and family members - experience vicarious trauma (Gregory et al., 2017). Vicarious trauma is an arguably unavoidable consequence of empathically engaging with a survivors' traumatic narrative over time (Bell et al., 2003). Empathic engagement necessarily effects the listeners' personal feelings, thoughts, memories, sense of meaning and safety (Hernandez-Wolfe, 2018). Research suggests that working with "human induced trauma", as opposed to that which is naturally occurring, can result in even greater vicarious trauma (Cunningham, 2003). Signs of vicarious trauma often mirror primary traumatic stress responses, including changes to assumptions that the world is meaningful and benign, that one's self is worthy and that others can be trusted (Hernandez-Wolfe, 2018; McCann & Pearlman, 1990; Mollart et al., 2009).

The studies reviewed from the field suggest motivations for practice and the management of burnout and vicarious trauma by survivor therapists, psychiatrists, social workers and mental health workers that could be beneficial for other helping professionals, like health professionals (i.e. nurses, doctors, etc). Workplace awareness of vicarious trauma, how it might impact all staff, as well as at-risk staff within an organisation, and other relevant factors (i.e. organisational, cultural), could be potentially important to the mitigation of, and support for, vicarious trauma. The present study captured a moment in participants' lives; however, the long-term implications of clinical care for survivors when the health professional shares DFV lived experience, are unknown, as is the support required to best sustain this work.

Conclusion to first key finding

This concludes discussion of the first key finding of this Chapter: that DFV appeared to be a frequent and possibly cumulative trauma in the lives of the health professional women who participated in this study. This key finding has implications for policy, practice and research which will be explored in the next Chapter. Wounded healer literature was drawn on, suggesting that survivor health professionals may be, at least in part, motivated by, or have grown from their traumatic experience. This section was concluded with a review of the vicarious trauma research, which cautions that while all those exposed to the trauma of others may be affected, particular issues should be considered with reference to those with lived experience of DFV. The second of the three key findings of this thesis was an association between clinical care and DFV exposure, and it is in this direction that the Chapter now turns.

7.5 ASSOCIATIONS BETWEEN DFV EXPOSURE & CLINICAL CARE

The second key finding of this thesis is that the survivor health professionals appeared to have undertaken more clinical care of survivor patients than their peers without a personal experience of DFV. Being a survivor health professional was associated with having attended one or more days of DFV training, holding more sensitive attitudes about survivors and an increased likelihood of having accessed DFV information to give to survivor patients during the previous six months. In turn, DFV training demonstrated a graded relationship with all aspects of DFV clinical care. To build a context for these findings the concepts of growth after trauma and resilience in healthcare will be discussed.

7.5.1 Associations between DFV exposure & training

While a possible interaction between DFV training, personal experience and clinical care has been suggested previously (Gutmanis et al., 2007), the finding of a relationship between exposure to DFV and preparation for practice through substantial attendance at DFV training (eight or more hours), is critical and new. While this finding has not been documented before, it does reflect the anecdotal experience of people who have experience of facilitating DFV training. In the absence of background literature, a hypothesis about DFV training had not been posited. This finding may be explained by survivors’ having a greater motivation to prepare for clinical care of survivor patients than their peers or might reference survivors’ own experience in some way. Survivor health professionals’ attendance at DFV training resonates with the literature about survivors being more sensitive and empathic to the experience of others with whom they share a trauma background (Jenkins et al., 2011). Lived experience may prime survivor health professionals to expect survivors among their patients and want to prepare for them. Referencing their own experience, if a survivor health professional has had a negative encounter of help-seeking in the past, they may be motivated not to repeat that by attending training to improve their readiness for practice.

The second possible explanation for the finding that survivor health professionals appeared more likely than others to have attended DFV training is that they may be in pursuit of information or validation about their own experience. This processing or making sense of experience may be intuitive rather than conscious (Elliott & Guy, 1993; Farber et al., 2005). It is possible that professional DFV training enhances health professionals' understanding about the needs of their survivor patients and contributes to how they themselves make sense of, cope with, and grow from experience.

DFV training was associated with most aspects of preparedness, identification and response to survivor patients. Regardless of a health professional's personal exposure to DFV, having undertaken at least one day of professional DFV training, at work or university, at any time in the past, was positively associated with eighteen of nineteen aspects of DFV clinical care. Health professionals who had been trained were more likely to ask their patients about DFV, identity survivors and respond by providing information, risk assessment, safety planning and referral. This finding is consistent with extensive literature that has found training to be effective in positively changing DFV practice (Dickson & Tutty, 1996; Gutmanis et al., 2007; Rodriguez et al., 1999; Sammut, Kuruppu, Hegarty, & Bradbury-Jones, 2019; Short, Surprenant, & Harris Jr, 2006; Stenson & Heimer, 2008; Zaher, Keogh, & Ratnapalan, 2014). These findings are not, however, consistent with those of Christofides and Silo (2005) who found no association between DFV training and identification of survivor patients in practice. Previous studies have tended to evaluate a particular training model or follow up the effect of training after a specified period of time (Short, Surprenant, et al., 2006; Zaher et al., 2014). The present study's findings suggest that DFV improves practice irrespective of when the training occurred or who the provider was.

7.5.2 Associations between DFV exposure & clinical care

Exposure to DFV was associated with indicators of readiness for practice beyond DFV training, including holding more sensitive survivor attitudes, and providing DFV information to patients. These findings remained even after adjusting for potentially confounding factors. It is important to note, however, that while a statistically significant difference between the attitude scores of survivor staff compared to their non-abused peers was found, interpretative caution is needed (Short, Alpert, et al., 2006). The actual mean difference between the PREMIS attitudes scores of these two groups was 0.4 points on a 7-point scale (Short, Alpert, et al., 2006). While this was a statistically significant difference, it may not indicate a meaningful or practical difference in the attitudes between the two groups (Harrington et al., 2019). Importantly, there was no difference between survivor health professionals and their non-victimised peers with reference to whether it was upsetting to discuss DFV with patients. Of note, survivor health professionals routinely outperformed their non-abused peers regarding DFV patient enquiry at a level approaching significance, although there are acknowledged problems with "near significance" reporting (Gow, 2016).

The finding of an association between a health professional's history of DFV and aspects of clinical care with survivor patients echoed limited previous research (Candib et al., 2012; Christofides & Silo, 2005; Dickson & Tutty, 1996). The study by Candib et al. (2012) of 380 physicians found DFV exposure was associated with feeling more confident to screen patients but did not lead to a self-reported change in practice. The research by Christofides and Silo (2005) of 212 nurses found that secondary, but not primary DFV exposure (i.e. through family and friends), was positively associated with DFV patient care. Similarly, the small study by Dickson and Tutty (1996) of 125 nurses' thoughts, feelings and proposed actions in response to identifying survivor patients found an association between secondary, but not primary, DFV exposure. Along with other limitations, none of the above studies adjusted for the influence of potentially confounding variables in their analysis. The present study has thus extended the field of research about associations between health professional DFV exposure and patient clinical care. These findings suggest that survivor health professionals may hold more sensitive attitudes about survivors and fewer misconceptions about DFV because of empathy stemming from a shared trauma experience (Jenkins et al., 2011; Jung, 1961) and may be even more likely to access DFV information for their patients because they believe that DFV awareness is an important intervention in itself.

This Chapter will now turn to an exploration of factors that may help explain survivor health professional readiness including the concepts of Posttraumatic Growth (Calhoun & Tedeschi, 1998) and Vicarious Resilience (Hernandez-Wolfe, 2018). While this study did not ask specific questions related to these concepts, as this Chapter has begun to establish, growth and resilience in the aftermath of trauma are indicated by the PhD findings, and learnings from them may be useful in the pursuit of enhancing support for the hospital workforce.

7.5.3 Posttraumatic growth

If survivor health professionals are indeed motivated to better prepare and care for survivor patients, could this indicate posttraumatic growth in progress. Distinct from the concept of resilience, which stems from the human capacity to adapt, posttraumatic growth describes positive psychological change, as well as the process of change, that can evolve out of the challenges and struggles of trauma (Calhoun & Tedeschi, 1998; Tedeschi & Calhoun, 1996). One model to explain posttraumatic growth is that traumatic crisis alters a survivor's assumptions about the world, effectively invalidating them, which, after a period of rumination, can lead to new meaning and personal change (Cann et al., 2010; Cobb, Tedeschi, Calhoun, & Cann, 2006; Tedeschi & Calhoun, 1996; Valdez & Lilly, 2015). While the theory of posttraumatic growth may sit uncomfortably for people who well know the harm and loss that DFV contributes, posttraumatic growth can sit alongside the well-documented devastating impacts of trauma, and from the outset, the posttraumatic growth field has sought the experience of DFV survivors (Cobb et al., 2006; Tedeschi & Calhoun, 1996). Posttraumatic growth is not about returning to pre-trauma baseline psychological functioning, nor is it about engineering a positive response in the aftermath of a crisis. Rather, it describes and categorises the organic growth experience that emerges for some people from the profound struggle that they have gone through (Harms et al., 2018).

Aspects of change can include personal strength, appreciation of life, spirituality and belief about new possibilities in relation to others (Harms et al., 2018). A systematic review of 12 quantitative and four qualitative studies about posttraumatic growth among survivors of interpersonal violence investigated different stages of change regarding the relationship with the perpetrator (Elderton, Berry, & Chan, 2017). The review found that survivors can experience quite high personal growth after DFV trauma, however this is not a universal outcome (Elderton et al., 2017). Growth appears to be moderated by a variety of factors, including whether the survivor is still in a relationship with the perpetrator, which reduces growth (Elderton et al., 2017). While posttraumatic growth describes positive change arising from the primary experience of trauma (Tedeschi & Calhoun, 1996), Vicarious Resilience is a concept focused on growth that can happen for a clinician from their trauma work with clients and it is this concept that the Chapter now focuses (Hernandez-Wolfe, 2018).

7.5.4 Vicarious resilience

Vicarious resilience has relevance for health professionals and may help meaningful interpretation of the PhD finding that DFV exposure was associated with enhanced DFV clinical care. Vicarious resilience is the recently described concept of how caring or therapeutic work can lead to positive growth for helping professionals, not just their patients or clients (Hernandez-Wolfe, 2018). Emerging from the field of therapeutic counselling and social work, vicarious resilience focuses on the reciprocity that occurs within therapeutic relationships, whereby counsellors and social workers may learn from, and positively change with, their clients (Hernandez-Wolfe, 2018). The concept of vicarious resilience may assist in understanding some of the research already canvassed in this Chapter including that which has found survivor helping professionals can demonstrate reduced trauma symptoms compared to survivors working in other fields, and appear less affected by stress and burnout (Elliott & Guy, 1993; Follette et al., 1994; Kinman & Grant, 2011). Vicarious resilience is linked with vicarious trauma; vicarious resilience theorises the positive aspects of transformation stemming from empathy, while vicarious trauma describes the negative impacts (Pearlman & Macian, 1995). Vicarious resilience, like vicarious trauma, could add to a holistic approach of understanding and supporting health professionals in the work they do.

7.5.5 Challenging what it means to be a DFV survivor

This current research challenges the notion of who survivors are, what walks of life they come from, and jobs they do. All professional groups in this thesis appeared to have been exposed to DFV as commonly or more commonly than the broader community (Cox, 2015; McLindon et al., 2018). Moreover, the survivors in this study were indicated to be doing more of the work seen as good practice with survivor patients; their job to help others to full health (McLindon et al., 2019). The idea that women who have experienced DFV are enduringly vulnerable is just not reflected in this research. This deficits-focused distortion could reinforce silence around DFV, especially at work, if survivors fear they will not be believed, or be judged as being unable to do their job, have their autonomy compromised, or face negative consequences from speaking up (McFerran, 2011). The women in this study were in clinical employment at a tertiary maternity hospital at the time of the research. To get there, each participant had worked and studied their way through a minimum of three to four years of tertiary training just to qualify for entry into the field. This sample were mostly quite experienced, with three quarters having been in their profession for ten or more years. All of the survivor participants had achieved their career and were now engaged in helping others whilst either recovering from, or living with, violence. This research should challenge misconceptions about what a ‘domestic and family violence victim looks like’ and the sometimes-unspoken implication that survivor women are persistently vulnerable. In the next Chapter, harnessing the power of lived experience as a force for positive change to better support survivor women will be discussed.

Conclusion to the second key finding

Discussion of the second key finding of this thesis - that personal exposure did not appear to be a barrier and could assist in facilitating clinical care with survivor patients – is now concluded. This research suggested that health professionals’ cared for survivor patients despite their own experience of DFV suffering, or perhaps, indeed motivated in part because of it. Here, the lens of posttraumatic growth and vicarious resilience were applied. This section raised implications for the support and professional development of health professionals by healthcare organisations in terms of DFV training offered to staff, clinical care policies and workplace supports – all of which will be explored in the next Chapter. The third and final key finding of this thesis, that the organisation has an important role to play in the support of survivor staff, will now be discussed.

7.6 HOSPITAL WORKPLACES SUPPORTING SURVIVOR STAFF

Discussion of the final key finding of this thesis centres on the role of the hospital workplace in responding to staff survivors of DFV. In light of the findings that DFV appeared to be common among health professional women and may help facilitate clinical care of survivor patients, this research sought to understand how hospital workplaces could and should respond to survivor staff. While pre-existing research with survivor employees in other employment sectors was drawn on, hospitals are unique, usually female-dominated workplaces that necessarily expose their employees to vicarious trauma and occupational violence (Pich et al., 2017). A clear argument can be made for understanding the needs of this specific group of employees. Findings were that the views of survivor health professionals and key stakeholders (hereafter referred to as 'managers') about how hospitals should respond were largely aligned. However, there was a notable divergence on the topic of the challenge that addressing staff DFV could present. Three themes emerged from survivors and managers about how hospital workplaces can respond to survivor employees: *Understand that DFV affects staff, Support for staff is essential,* and *There are challenges to establishing a safe workplace.* Here, these themes will be discussed in the context of the literature.

7.6.1 DFV at home impacts survivors at work

There is a growing body of evidence about the role workplaces have in recognising and responding to staff experiences of DFV (MacGregor, Wathen, Olszowy, et al., 2016; McFerran, 2011; Perrin, Yragui, Hanson, & Glass, 2011; Rayner-Thomas et al., 2016; Rayner-Thomas et al., 2014; Swanberg et al., 2007; Wathen & MacGregor, 2014). While this literature has developed outside the healthcare-specific field, it is largely premised on the idea that the workplace is an opportune site for assistance with the impacts of DFV because survivors spend much of the time they have apart from their partner in that environment (Lindquist et al., 2010). Additionally, since DFV costs organisations, if addressed, what is good for employees should be good for business in the long-term (Rayner-Thomas et al., 2014).

This study's finding that survivor health professionals and managers were frequently aligned in their views about the importance of addressing DFV in the lives of staff diverges from other literature (Reynolds & Perrin, 2004; Yragui et al., 2012). Using standardised measures, Yragui et al. (2012) interviewed 163 survivor employees about their experience of DFV, supervisor support and work outcomes during the previous 12-months. They found that survivor employees often reported a support mismatch with their manager, either by being offered a form of support they did not find helpful, or by receiving an unwanted response (Reynolds & Perrin, 2004; Yragui et al., 2012). Research about workplace support with a non-DFV health issue (cancer) has found that women's support needs of their employer can vary considerably and that women should be asked at the beginning of a period of support about their needs and the aspects of a workplace response they might find unhelpful (Reynolds & Perrin, 2004). The present study attempted to ask survivor health professionals what response they would like from their workplace before that workplace had developed a formal response, rather than evaluating receipt of a workplace support program after its introduction.

7.6.2 The needs of health professional survivor employees

The survivor staff in the current study wanted increased awareness from their workplace that DFV had affected them, not just their patients, in order to confront and dismantle stigma and isolation. This finding is consistent with that of Glass et al. (2016) who found increased DFV awareness in the workplace was a core component of creating a "safe, supportive and positive workplace climate for survivors" (Glass et al., 2016, p. 539). Survivors in the present study echoed concerns raised in previous research about employment repercussions if their experience of DFV was known (Swanberg & Macke, 2006; Swanberg et al., 2006). This fear is valid since research has shown disclosure is associated with decreased hours at work and problems maintaining employment (Browne & Salomon, 1999). A study by Lloyd (1997) of 824 low income women found that survivors were more likely than their peers to experience health problems and periods of unemployment. One way of increasing DFV workplace awareness might be through the development of a workplace environment that is not disclosure dependent (McFarlane et al., 2000). Additionally, employees and managers should be resourced to recognise indicators of DFV among their colleagues and provide a supportive response (McFarlane et al., 2000). This would re-cast deteriorating work performance or tardiness as possible indictors of DFV, rather than individual failings of an employee (Rayner-Thomas et al., 2014).

More than half of the survivors in the present study identified that DFV had affected the way they worked. For some, this impact was described in positive terms, including increased empathy and awareness. Survivors spoke through the survey of multiple impacts at work, affecting both their functioning and their clinical care of patients. More commonly however, survivors raised the challenging toll. As many as half of the survivor participants had experienced abuse intrude onto the workplace among other negative impacts. These impacts included reductions in the survivor's capacity to function and physical and psychological injuries like anxiety, depression, tiredness and distraction. This impact finding is consistent with much other research (Crowne et al., 2011; MacGregor, Wathen, Olszowy, et al., 2016; McFerran, 2011; Rayner-Thomas et al., 2016; Rayner-Thomas et al., 2014; Swanberg et al., 2006). Reactions to DFV are fluid, not static, and it is likely that the impacts of DFV evolve over time. Other staff described how the healthcare workplace could trigger memories of their distress through both training and patient work. Managers recognised this secondary exposure risk too, using terms including, "double jeopardy" and "occupational hazard". These indicators of the DFV toll at work underscore the need for a supportive workplace response specifically tailored to the hospital environment.

7.6.3 Aspects of a supportive hospital workplace response

Given the findings about the impact of DFV at work, this study reinforces previous research about the importance of nuanced workplace support, including through schedule flexibility (Australian Human Rights Commission, 2015; Glass et al., 2016; Swanberg et al., 2007), DFV workplace policies (Glass et al., 2016; Murray & Powell, 2007), clear communication, assurances of confidentiality backed up by procedures (Aupperle, Melrose, Stein, & Paulus, 2012) and the provision of skilled people with whom to talk (Kulkarni & Ross, 2016). Indicating, perhaps, where hospitals depart from other workplaces, survivors wanted ready access to confidential onsite specialists for debriefing if their trauma response was triggered in the course of clinical work with survivors. Beyond this, some survivors wanted to be able to speak to DFV specialist counsellors for longer-term recovery-orientated support. Research by Perrin et al. (2011) has suggested that the level of support survivor employees want from their employer may reflect the stage of relationship change they are in. Survivors who needed a lot of varied support were potentially facing the most danger in their relationship, compared to survivors requesting minimal support (Perrin et al., 2011). All of the supportive interventions mentioned by survivors in the present study may be critical to creating an environment where staff feel safe to disclose DFV, disclosure results in support and employment is protected through anti-discrimination infrastructure (Australian Human Rights Commission, 2015; Katula, 2012; Swanberg et al., 2007).

7.6.4 The role of managers

There was another form of workplace support that survivor staff in this research were united in judging as helpful. This was that key people within the organisation to whom a disclosure may be made - managers, HR and Employee Assistance Program staff - should be trained to be able to provide a sensitive and informed response to employee DFV disclosures. This finding is consistent with other studies that have found that survivors want their workplace to better understand DFV and respond sensitively, and managers want to build their knowledge and capacity (Glass, Bloom, Perrin, & Anger, 2010; Glass et al., 2016; Laharnar et al., 2015; Rayner-Thomas et al., 2016). In pre and post-test studies, training has been shown to increase manager's and supervisor's willingness to intervene with survivor employees, their understanding about DFV and their perceived skills to respond (Glass et al., 2010; Glass et al., 2016; Navarro, Jasinski, & Wick, 2014). However, the effect of training seems limited to those who undertake it, with Glass et al. (2016, p. 543) finding training effects are not "diffused throughout" the organisation to people who have not participated in training themselves.

7.6.5 DFV leave

The final dimension of workplace support raised by survivors in the present study was DFV leave. In recent years, DFV leave has become increasingly common in workplaces across Australia (Baird, McFerran, & Wright, 2014). However, at the time this research was undertaken, DFV leave was not yet available at the research site. Without a specific interview schedule question on this topic, many of the managers in this study volunteered their view that DFV leave was an important form of support. Other managers suggested practical and economic concerns about such leave. Survivor health professionals were tepid on the topic of DFV leave, expressing concern about confidentiality and repercussions if leave was disclosure dependent. This finding speaks to that of McFerran (2011) who found paid leave to be the most frequent assistance offered to employees after disclosure. Those survivors who chose not to disclose though, were primarily concerned about privacy breaches if they accessed DFV leave (McFerran, 2011). This concludes examination of the aspects of workplace support that emerged from the survivors and managers in this study. Discussion now turns to the issue of safety in the workplace environment.

7.6.6 Safety at work

Concerningly, feeling unsafe at work was not uncommon among the survivors in this study, with more than half reporting violence or abuse by patients or colleagues. This finding was consistent with recent Australian and international studies that have identified violence and aggression from patients and visitors to be a major issue for healthcare workers (Binmadi & Alblowi, 2019; Rees, Wirihana, Eley, Ossieran-Moisson, & Hegney, 2018; Shea et al., 2017). Bullying and harassment from colleagues, was another challenge that participants in this study shared with health professionals who have participated in other research on the topic (Level Medicine, 2019; National Academies of Science Engineering and Medicine, 2018). Occupational violence has its own impacts on the health and safety of affected employees (Pihl-Thingvad, Elklit, Brandt, & Andersen, 2019) and has been linked to absenteeism and job loss (Laharnar et al., 2015). The findings of this study present safety as a core aspect of a workplace environment in which staff feel able to talk about DFV and seek support. When thinking about improving a hospitals' DFV response towards staff, safety from occupational aggression must be seriously addressed. The survivors and managers in this study suggested that improving occupational safety could have several implications: minimised harm to employees and a message sent that the employer cares about the safety of their workforce, reduction in the potential for traumatic memory triggers on the job, and finally, the evolution of an environment in which staff feel emotionally and physically safe to talk about DFV at home and its affect at work.

Conclusion to the third & final key finding

This concludes discussion of the third and final key finding of this thesis about the role of the hospital workplace in responding to survivor employees. Survivor health professionals and hospital managers were largely aligned in the view that hospitals need to understand, support and ensure the safety of their staff as both survivors and health professionals exposed to DFV in their clinical work. As far as is known, this PhD research is the first hospital-specific workplace research that has been conducted. The findings reinforced the generalist workplace response literature.

7.7 CONCLUSION

This Discussion Chapter placed the core contributions of new knowledge offered by this study in a broader context of the DFV prevalence and impacts literature, extending to other fields of knowledge to augment contemplation of these results. The first major finding was that DFV had affected a substantial proportion of health professional women, suggesting a higher prevalence than the community. In this context, wounded healer literature was drawn on to explore whether DFV may be consciously or unconsciously related to motivation or heightened capacity to care for others. One of the impacts of DFV against health professional women indicated by the results was enhanced clinical care of survivor patients – the second major finding. In this research, survivor health professionals did not present as enduringly vulnerable, rather, they demonstrated readiness to respond to patients in a sensitive and informed way, and these findings were grounded in posttraumatic growth and vicarious resilience literature. While trauma impacts are individually expressed, multidimensional and tenacious, enhanced empathy and skill can grow from trauma, and may even contribute to strengthened mechanisms for coping with secondary stress. The third major finding of this study was survivors' call for understanding, resourced and safe workplaces, which bolsters the generalist DFV and employment evidence base. Vicarious trauma is a very real challenge for everyone exposed to adversity and violence against others and the literature advocates extra considerations for survivor professionals. This has ramifications for highly gendered hospital environments where the prevalence of trauma at home appears high, survivor employees may assume a greater share of the DFV clinical care load and onsite occupational aggression is not uncommon.

The next Chapter presents the implications and conclusions of this thesis. This final Chapter begins with an examination of the overall strengths and limitations of the study. The knowledge translation piece of this work is described, as are the implications for hospital policy and practice. A framework for a whole-of-hospital approach to safety, care and recovery is presented and the research questions that remain upon conclusion of this thesis are advanced.

8.

Implications & Conclusions

"I think this is a very important issue and, in my role, I sometimes feel compelled to talk to women about domestic violence they are experiencing but don't know whether it is my place to intervene."

(Survivor health professional participant)

"We need the people in our workplace to feel that they can give the best of themselves, both for their own fulfilment, and for the welfare of the organisation, which is a proxy for the patients that we look after."

(Hospital manager participant)

8.1 OVERVIEW

This final Chapter considers the implications and conclusions of this thesis about DFV against Australian health professional women. Beginning with a summary of the approach and content of this thesis, a reflection on the strengths and limitations of this study follows. The Chapter describes the new learning that this research contributes to the field, followed by knowledge translation to reduce the evidence-to-practice gap. The implications of this research for practice, policy and procedure culminate with the introduction of a trauma and violence informed framework for hospitals. Finally, the questions that endure unanswered are identified and future research explored. Within this Chapter, I will use the first-person pronoun when reflecting on my experience of the project.

Summary of the approach & content of this thesis

The aim of this thesis was to investigate the prevalence, impacts and implications of DFV against Australian health professional women in response to a clear gap that was identified in the evidence. Through a combined methodological approach encompassing a cross-sectional survey of 471 health professional women at a single tertiary hospital and 18 interviews with hospital key stakeholders, four research questions were asked. In response to research question one*, What is the prevalence of DFV and other interpersonal violence in an Australian health professional population?,* this thesis found that DFV appeared to be common in the lives of Australian clinicians, with one in ten having experienced violence by a partner in the last 12-months, and 45.0% having survived lifetime DFV. In answer to research question two, *Do health professional's personal experiences of DFV affect their attitudes about DFV, comfort to discuss the issue with women, enquiry, and response towards survivor women?,* findings indicated that compared to non-abused health professionals, being a survivor health professional was positively associated with providing clinical care to survivor patients. This included through higher uptake of training, demonstrating more sensitive attitudes about survivors and accessing more DFV information for patients. The exploration of research question three: *What support needs do survivor health professionals have of their hospital workplace?* concluded that survivors wanted their workplace to understand them, support them and ensure a safe working environment. Finally, the response to research question four: *What are the views of key stakeholders about the role of the workplace in responding to staff survivors of DFV?* was that supporting staff survivors was core hospital business and overcoming barriers to survivor disclosure is critical to address.

8.2 STRENGTHS & LIMITATIONS OF THE STUDY

This section outlines the overall strengths and limitations of this PhD, including being an *insider* researcher, issues to do with participants and the recruitment site, DFV measurement, recall, bias, the response rate and aspects of the qualitative method.

Insider researcher

On balance, being an insider researcher was a strength of this project. As a hospital social worker employed at the research site, I both administered the survey and conducted the interviews. This likely facilitated greater access to participants, organisational "buy-in", and extra resources to be able to practically demonstrate gratitude to potential participants. As a result, participants may have felt enhanced trust to participate in both phases of the research and may have exhibited greater openness during their participation (Braun & Clark, 2013). Further, the capacity to meaningfully translate these findings into better support for survivor women, as will be discussed further in this Chapter, was greatly enhanced.

Participants & recruitment site

A strength of this study was the diversity of health professional backgrounds among the participants, and the representativeness of each group (Candib et al., 2012; Christofides & Silo, 2005; Dickson & Tutty, 1996; Early & Williams, 2002; Moore et al., 1998). Another asset was the recruitment of primary DFV survivors. Much of the work in the DFV against health professional field has been done with secondary trauma survivors, with consequent learnings restricted (Dickson & Tutty, 1996; Early & Williams, 2002; Gutmanis et al., 2007; Moore et al., 1998). A limitation of this study was the single recruitment site used, which prevents generalisability of the findings (Kirkwood & Sterne, 2003). Also, given the cross-sectional design of this study, associations can be inferred, e.g. the direction of the abuse/work relationship, but causation cannot be implied (Kirkwood & Sterne, 2003).

Measurement of DFV

The use of a well-validated measure of IPV during the last 12-months was a strength of this study (Hegarty et al., 2005). Use of the CAS extended the field of research about DFV against health professionals because it is a more comprehensive and rigorous measure of IPV than has been used by previous studies in this field (Al-Natour et al., 2014; Bracken et al., 2010; Candib et al., 2012; Cavell Nurses' Trust, 2016; Christofides & Silo, 2005; deLahunta & Tulsky, 1996; Diaz-Olavarrieta et al., 2001; Doyle et al., 1999; Early & Williams, 2002; Janssen et al., 1998; Khan et al., 2014; Mitchell et al., 2013; Rodriguez et al., 1999; Sharma & Vatsa, 2011; Stenson & Heimer, 2008). In addition, this thesis would appear to be the first study to extend the CAS beyond 12-months (Hegarty et al., 2005).

However, one problem that emerges from the use of different DFV measures in this field of research is the prevention of accurate comparison, and this challenge was confronted when trying to situate the 12-month and adult lifetime IPV findings into the broader context of the literature. Further, it was determined to be important to obtain an indication of cumulative interpersonal trauma in health professionals’ lives by asking bespoke questions about non-intimate partner family violence and other interpersonal violence (i.e. by patients, friends etc). The reason that a validated measure was not used (for example: MacMillan et al., 1997), was onerousness and sensitivity on a topic that was not the main focus of this study. In addition to limiting negative impacts of participation, we simultaneously aimed to maximise the response rate (Edwards et al., 2010). Nonetheless, the choice not to use a standardised measure is an acknowledged limitation of this study.

Recall of abuse over time

Self-report and social desirability are well-documented issues in DFV research that are associated with the underreporting of abuse (McNutt & Lee, 2000; Visschers et al., 2017). A survivor may choose not to report because she feels ashamed, or because the impact of recalling is traumatic or because she thinks her experience is too trivial to mention

(Visschers et al., 2017). While we thought it was important to ask about lifetime abuse, it is also a limitation of this study because of the potential for recall problems. One problem with asking participants to recall long time periods is that of "telescoping"; the concern that participants might remember incidents as happening more or less than they actually did (Smith, 1987). As was canvassed in some detail in Chapter 4 (page 131), participants did appear to recall types of abuse differently when asked about the last 12-months compared to the adult lifetime. More commonly, participants' recalled emotional abuse and harassment during the preceding 12-months and combined physical and sexual abuse over the adult lifetime. In the absence of evidence that non-physically abusive behaviours recede over time, this finding hints at the underreporting of lifetime emotional abuse and harassment in this study. In studies of prevalence variations, under-reporting is seen to be the contributor and a significant concern in DFV research (Ellsberg et al., 2001). Over-reporting, on the other hand, is thought to be rare because of shame, stigma and possible trauma impacts of recalling DFV memories (Ellsberg et al., 2001).

Bias in the quantitative method

Bias in cross-sectional studies is defined as the deviation of the study's result from a true outcome or value (Vandenbroucke et al., 2014). It is often introduced during project design or implementation, rendering remedial attempts futile (Vandenbroucke et al., 2014). Potential sources of 'response' or 'selection' bias were addressed *a priori* by maximising the response rate whilst observing ethics committee directions that limited both the number of reminders and the recruitment timeframe. Some of the survey measures contained intentional negative wording to minimise response bias. '*Information*' bias was reduced by adjusting for the influence of potentially confounding variables in the regression analysis (Candib et al., 2012; Christofides & Silo, 2005; Dickson & Tutty, 1996; Early & Williams, 2002; Moore et al., 1998; Vandenbroucke et al., 2014).

Response rate

Considerable attempts were made to maximise the proportion of health professionals who participated in the project, and a 45.0% response rate was achieved. The response rate is an acknowledged limitation since people who participated in this study may have differed in a meaningful way from those who did not. For example, survivors of violence may have been more interested and willing to participate than other people (McNutt & Lee, 2000). A two-decades old meta-analysis aimed at determining a reasonable response rate for academic studies in health, behaviour and management recommended that a response rate norm be considered >55% (Baruch, 1999). However, many things have changed in the landscape since the publication of that paper and researchers have found a decreasing number of individuals now agree to participate in surveys, resulting in response rate decline (Manzo & Burke, 2012). Despite the sample limitations, and weighing the sensitive nature of this survey; the work demands of these participants; the representational participation of nurses, doctors and allied health professionals; and the precedent response rate of whole-staff surveys at the research site (~30%, B. O'Brien, personal communication, 1 August 2012); we argue that the response rate achieved is acceptable and comparable to similar research (Candib et al., 2012; Christofides & Silo, 2005; Edwards et al., 2002).

Use of open-ended questions

This study's "combined methodological approach" incorporated two distinct participant groups, and two methods of data collection, which could be viewed by some as a limitation because of the potentially divergent theoretical paradigms and the risk of not attending enough to context (Barbour, 1998). However, this method was chosen to extend the quantitative findings meaningfully by exploring the practical role hospital workplaces can have in responding to survivor staff. Method and data source triangulation can strengthen a study through the contribution of deeper understandings arising from different perspectives (Carter et al., 2014). Nevertheless, an acknowledged limitation of the method was the use of open-ended survey questions to gather qualitative data. While this method was an ethical and pragmatic decision for this project and is considered an acceptable method for identifying and analysing patterns of meaning, it is nevertheless likely that the depth of the qualitative data provided by survivor participants was inhibited by this approach (Braun & Clark, 2013; Kulkarni & Ross, 2016). A strength of the qualitative method overall was the rigorous data analysis, which included investigator triangulation (Carter et al., 2014).

8.3 ORIGINAL KNOWLEDGE CONTRIBUTIONS OF THIS THESIS

Accounting for the strengths and limitations of this project, it is argued that this thesis represents a unique and important contribution to research about DFV. This study was the first to measure the prevalence of DFV in an Australian health professional population of nurses, doctors and allied health professionals, finding that DFV was common (McLindon et al., 2018). The measurement of prevalence was the most methodologically rigorous among the studies on this topic given the use of the CAS, the response rate and the representation of different health professionals (Hegarty et al., 2005). Further, for the first time, a reliable answer can be given to the question of whether DFV against health professional women is associated with their clinical care of survivor patients (McLindon et al., 2019). Lived experience of DFV does not appear to be a barrier and may, in fact, facilitate good clinical care of survivor women (McLindon et al., 2019). This was a more robust study of the important association between DFV exposure and clinical care than others in the field because potentially confounding variables were adjusted for in the analysis. Moreover, the research was done with primary, not secondary, DFV survivors. This research also presents a unique contribution to knowledge by being the first to study DFV staff support in a hospital workplace. Survivor health professionals wanted a multifaceted program of support within a safe workplace and managers believed hospitals have a responsibility to prepare and sustain such an environment (McLindon et al., 2020). This thesis indicates that a trauma and violence-informed framework, strengthened by the voices of survivors, could underscore more sensitive and healing hospital responses towards survivor staff and patients (Harris & Fallot, 2001). The principles of such a framework for hospitals will be elucidated further in this Chapter.

8.4 KNOWLEDGE TRANSLATION

This project did not occur in an academic vacuum. My motivation for doing this research was to contribute to clarity about the experiences of survivor staff and how things could be better. I was not alone in that motivation. Others generously wanted to collaborate with me to fill the gap between the evidence presented by this research and the reality for staff in hospital workplaces that neither recognised DFV against health professional women or had a planned response for support. I have been privileged to see this project interact with and change the environment out of which it was born.

8.4.1 Strengthening hospital responses to survivor staff

Strengthening hospital responses to DFV is work I began long before commencing this PhD study. At the hospital where this research was conducted and where I am a social worker, I had a special interest in improving hospitals' capacity to respond to survivor patients. One aspect of this work was a monthly meeting a colleague and I co-facilitated with social work managers from other hospitals. The purpose of this collaboration was to support interested hospitals to strengthen their capacity to meet the needs of survivor patients through improving staff readiness, bolstering available resources, and smoothing the path through the system for survivors towards meaningful support. This ad-hoc group, run on top of the myriad competing demands of a hospital social worker and everyone else involved, gained momentum and eventually funding, to become the Strengthening Hospital Responses to Family Violence (SHRFV) program. SHRFV is a platform of work and resources that has evolved since 2014.

The initial purpose of SHRFV was to assist hospitals in Victoria, Australia, to develop and implement a framework for identifying and responding to survivor patients (Figure 14).

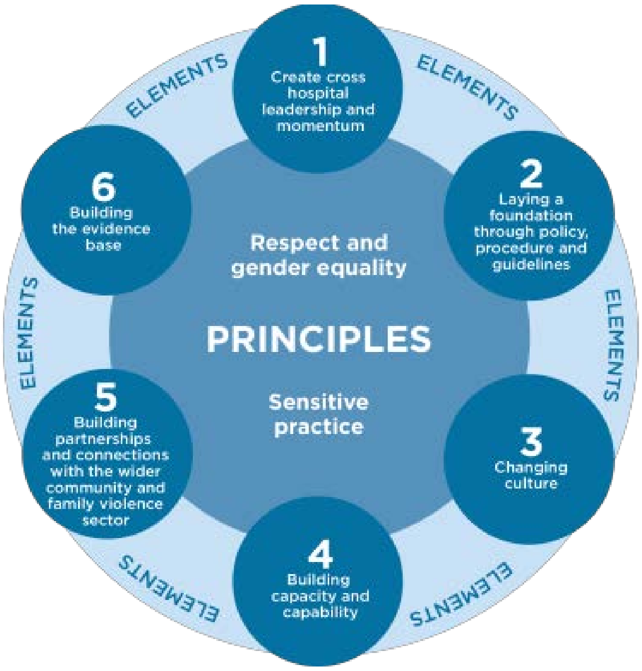

Figure 14. SHRFV principles: Pre-2016

(Strengthening Hospital Responses to Family Violence, 2015)

However, one of the benefits of doing research from within an organisation has been an interested and invested hospital audience to receive the findings of this thesis. Years before publication, I delivered results about the prevalence of DFV against health professionals to the hospital's Executive and Directors. Based on these findings, a SHRFV working group to establish workplace support for survivor staff was initiated, to which I contributed. The outcome of this working group was establishment of the first Australian hospital DFV workplace support program. The change to the principles underpinning SHRFV that was brought about by incorporating a focus on staff can be seen in Figure 15.

Figure 15. SHRFV principles: Current

(Strengthening Hospital Responses to Family Violence, 2019)

Citing my (at that time) unpublished PhD research, SHRFV approached the Victorian State Government for funding to lead this DFV workplace support program among other

Victorian public hospitals. In 2017, SHRFV was awarded $260,000 to guide hospitals to develop their own workplace response to staff affected by DFV. This staff-centred system-wide model brings together workplace policy, training and resources (Appendix X). At the time of writing, 97% of 88 Victorian public hospitals now have a policy, procedure and support for staff experiencing DFV.

Getting the message out

Throughout the course of this PhD, I have spoken to hundreds of health professionals at National and International conferences, Australian Nursing and Midwifery Federation (ANMF) congresses, several hospital grand rounds and through far reaching media (Appendix Y). The purpose of these talking events has been to share the findings of the health professionals who generously participated in this research, break the silence that DFV happens to clinicians, talk about the impacts, argue the important role workplaces occupy in supporting their survivor staff and suggest a model for support. Further, I have conferred directly with Victorian hospitals as well as the ANMF (Vic Branch) about effective DFV support they can provide to their tens of thousands of Victorian members. This includes consultation with the ‘Nursing and Midwifery Health Program’ to strengthen that service’s capacity to respond to survivors based on the findings of this study. Knowledge translation continues through publication and future research.

8.5 IMPLICATIONS FOR HOSPITAL POLICY & PRACTICE

This project has implications for hospital policy and practice with staff, which in turn, may impact the care of patients. Implications pertain to:

- Organisational culture;
- DFV training;
- Equipping managers;
- Workplace support;
- Addressing vicarious trauma and resilience; and,
- Survivor voices.

8.5.1 Organisational culture

Until recently, hospital organisations have rarely considered what it means if a health professional staff member is impacted by fear and violence in their home and attending a workplace where their job includes identifying and intervening with patients affected by these same issues. The culture of staff leaving their problems at the door when they enter the workplace is one based on patriarchal structures and gendered norms established in the early 20th century (Swanberg & Macke, 2006). In that era, a male head of household would attend work with the expectation of little or no family responsibilities; assumed to be able and free to work unlimited hours without juggling competing demands between work and home (Swanberg & Macke, 2006). While that employee mould does not fit many, or even most workers in the present day, the cultural expectation nevertheless persists (Swanberg & Macke, 2006). When family life is positioned as occurring within a domain firmly outside the workplace, the idea that 'what happens at home stays at home' is reinforced. This can create obstacles for employees to talk about difficult things that occur within families, or to ask for leave or flexibility if either is needed (Swanberg & Macke, 2006).

Additionally, hospital workplaces with a culture is not gender equitable, or where sexual harassment and bullying is not taken seriously, are unlikely to be organisations able to respond sensitively and supportively to a health professionals' experience of DFV (Wagner, Yates, & Walcott, 2012). The ideal is that workplaces do not rely on being disclosure dependent (i.e. to access DFV leave or other support resources) (Rayner-Thomas et al., 2014). Rather, by ensuring that support and information is available to all, DFV understanding and empathy can grow across the organisation so that survivors might feel comfortable to disclose. Strengthening a hospital response to DFV is work that requires organisational leadership and resources underwritten by policy (Strengthening Hospital Responses to Family Violence, 2019). Investing in this work may be difficult and costly, requiring leadership and buy-in from different professional groups. It will very likely require upkeep too, as staff, funding and priority areas within hospitals evolve (García-Moreno et al., 2015; Warshaw, 1989).

8.5.2 DFV training

DFV training is an important part of supporting health professionals' readiness for clinical practice with survivor patients (Zaher et al., 2014). The current study suggested that survivor staff may be overrepresented as participants in DFV training (McLindon et al., 2019). Given this, core components of DFV training for health professionals should acknowledge the commonality of trauma among staff, and the unique work of clinicians, starting the conversation about resources available for managing one's own experience alongside care of patients. Training should address the possibility for trauma triggered during routine care, teach emotional tools to manage such a response in the moment, and raise awareness about options for follow-up support. Naming vicarious trauma, its indicators as well as strategies for delaying onset and reducing impact could also enhance such training (Gates & Gillespie, 2008; Pearlman & Macian, 1995; Shakespeare-Finch & Daley, 2017).

8.5.3 Equipping managers

Ensuring that training is available and encouraged for all staff who might receive disclosures in a hospital workplace is important. However, there should be a particular focus on managers and HR staff whose responsibility often extends to decision-making about employment conditions, and whose support and understanding may be critical to keeping an employee at work. Equipping managers and staff to recognise some of the indicators of DFV, as the survivor staff in this research, and others, have named, is likely to be critical to a compassionate employment environment (McFarlane et al., 2000; McFerran, 2011). Poor work performance, tardiness, distraction, anxiety or appearing flat are all possible signs that an employee may be experiencing DFV or dealing with the impacts of historical trauma (Rayner-Thomas et al., 2014). Sensitively inquiring about how things are at home could be a good starting point when a manager sits down with an employee to discuss performance issues. Following DFV disclosure, managers asking survivors early on about the components of a supportive versus unsupportive response for them might avoid support mismatches down the track, assisting the survivor in her recovery (Reynolds & Perrin, 2004; Yragui et al., 2012).

8.5.4 Workplace support

A workplace that wants to support their survivor staff needs to signal that intention to them; research indicates that sending that message is associated with staff disclosure, support utilisation and more favourable outcomes reported by survivors (Rayner-Thomas et al., 2016; Swanberg et al., 2006). Developing a workplace program to support health professionals who have experienced DFV needs to include trained individuals available onsite and external to the organisation (Strengthening Hospital Responses to Family Violence, 2019). Onsite support may include social workers or other counsellors with DFV training employed for secondary consultation or debriefing with colleagues. Social workers are suggested here because they are a large group of allied health professionals already employed at most public hospitals (Australian Institute of Health and Welfare, 2013a). Further, DFV is usually part of both social workers' tertiary training and clinical experience; while counselling, supervision and secondary consultation underpinned by theory are essential skills held by even the newest graduate (Egan & Reese, 2018; Harms, 2010; Sawyer, Coles, Williams, & Williams, 2016). Partnering with DFV specialist organisations may be another way to link survivor staff with confidential and expert support if women choose to disclose DFV in the workplace (Rayner-Thomas et al., 2014). In a paper synthesising DFV in the workplace, Rayner-Thomas et al. (2014) suggest that highly unionised industries (e.g. nursing) work to strengthen anti-discrimination policies that affect their members and advocate for greater employee entitlements. Offsite, the recommendation of survivors in this study was that hospital Employee Assistance Programs have a screening process for DFV at intake, and counsellors with training and experience in the specialist field are made available to receive referrals.

8.5.5 Addressing vicarious trauma & vicarious resilience

Workplace programs and training that acknowledge the substantial burden of secondary trauma that health professionals are exposed to, may be protective (Kulkarni et al., 2013). This could include teaching an awareness of the early warning signs of vicarious trauma, normalising onset ('*it's not if but when*') so that barriers to staff self-identification are reduced and pathways for support towards recovery are established (Bell et al., 2003; Kulkarni et al., 2013). Research suggests that individuals can mitigate against the impact of vicarious trauma by doing the following: practising self-care, engaging in research, task variation, supervision and talking therapy (Kulkarni et al., 2013). Of course, it is the responsibility of organisations to both create the mechanisms and ensure the resources for staff to apply these suggestions. Organisations have a stake in staff self-care; they can assist in building the resilience of employees through prioritising it and providing opportunities for staff to practice self-care (Moore, Perry, Bledsoe, & Robinson, 2011; Newcomb et al., 2015). Certain organisational factors can decrease the resilience of staff and increase the risk of vicarious trauma and burnout, and the top concerns are high work demand, low job autonomy, repeat exposure to the same type of trauma in the lives of patients and low job satisfaction (Alarcon, 2011; Hernandez-Wolfe, 2018; Newcomb et al., 2015). Addressing these factors may enable an organisation to mitigate the onset and severity of vicarious trauma for staff (Alarcon, 2011).

This research indicated signs of posttraumatic growth and vicarious resilience among survivor staff, since DFV exposure was positively associated with aspects of clinical care (McLindon et al., 2019). Workplaces sharing the story of positive growth for health professionals, including strengthened practice, may reinforce and extend that growth (Hernandez-Wolfe, 2018). Supervision, reflection and peer support practice could include clinicians' reflections of what vicarious resilience means to them (Blanch, Filson, Penney, & Cave, 2012; Hegarty et al., 2017).

8.5.6 Positioning survivor staff as an asset to their workplace

The findings of this study provide evidence that survivor health professionals may be an asset to the organisations in which they work, debunking the myth that women who have experienced DFV are enduringly vulnerable (Jenkins et al., 2011). While the specialist DFV sector (the 'shelter' movement) was originally self-organised and grew out of the direct experiences of survivor women themselves, professionalism and mainstreaming of the DFV workforce - with tertiary degrees an employment prerequisite - has changed the narrative of what it means to work as a helping professional with lived experience of trauma (Hague & Mullender, 2006; McCarry, Larkins, Berry, Radford, & Stanley, 2018). In the important pursuit of not making the 'helper's' trauma the responsibility of the person being 'helped', a complete silencing of personal experience on the part of the helping professional may be an unintended consequence (Newcomb et al., 2015). The survivor clinician may feel fearful of judgment or employment retribution in response to disclosure (Hague & Mullender, 2006). While staff survivors are silent, however, they are unable to access workplace support that may be helpful to their recovery and their voices are prevented from being harnessed to inform and improve hospital responses for all survivors. It might be time to reposition what it means to be a survivor clinician, to more fully realise that in addition to harm, trauma can lead to deep understanding and empathy, positively influencing the work that health and other helping professionals do (Newcomb et al., 2015).

8.5.7 Harnessing lived experience to improve workplace responses

As canvassed in the Literature Review Chapter, women with lived experience are rarely engaged to inform service responses in a way that demonstrates meaningful and ongoing consultation – be they survivor staff or service users (Bond et al., 2018; Hague & Mullender, 2006). Survivor voices are essential to making organisations responsive to the people they serve, effective and focused on women's and children's needs (Blanch et al., 2012; Hague & Mullender, 2006; Sweeney et al., 2019). Taking this further, for a workplace response to effectively meet staff survivor needs, it follows that the views and experiences of staff survivors must be heard and heeded. To this end, a study by Hague and Mullender (2006) with specialist DFV service users could prove illustrative. In this study, survivors felt emboldened to raise their voices within an organisation when the following issues were considered and responded to: the survivor's sense of internal power, diversity and intersectionality, self-image, the "embarrassing and damaging effects of abuse", safety and confidentiality (Hague & Mullender, 2006, p. 577). When survivors are also staff, then additional issues including employment security and workplace safety will be critical (McFerran, 2011). The time is opportune for organisations to begin the work of harnessing the voices of those survivors who feel ready and able to speak – be they staff or patient (Mayer & McKenzie, 2017). Through a deeper understanding about lived experiences and the contribution and strengths of survivor staff, the organisational support response may be improved, and survivors encouraged to feel more comfortable seeking help for the impacts of DFV or vicarious trauma so that they can go on providing the best support possible to women (Newcomb et al., 2015).

8.6 A TRAUMA & VIOLENCE INFORMED CARE APPROACH

Trauma and violence informed care may provide a useful framework, overarching all of the suggestions made in this thesis about the components of a supportive workplace response, harnessing resilience and growth, and reducing the impact of vicarious trauma (Browne, Varcoe, Ford-Gilboe, Wathen, & Equip Research Team 2015; Harris & Fallot, 2001; Hopper et al., 2010; Levy-Carrick et al., 2019; Quadara, 2015). The benefit of a trauma and violence informed framework to guide the operation of an entire hospital system is that it is an approach that can encompass responses towards both staff *and* patients (Harris, Crilly, Stolee, & Ellett, 1999). A trauma and violence informed system is one in which all elements of that system have been organised with an understanding that trauma and violence are common and can have a centralising influence over a survivor's life (Harms, 2015; Herman, 1992).

'Trauma-informed care' has been a framework for practice with service users in mental health and human service systems in Australia (Harris & Fallot, 2001; Quadara, 2015), and overseas (Hopper et al., 2010), for close to two decades. However, it is not yet a model conceptualised for use in general Australian hospitals, and in most of the settings where it has already been adopted, it has been to guide patient/consumer/client care, not a response to staff (Quadara, 2015; Reeves, 2015). Shifting the language to trauma *and violence* signals a focus on the traumatic impact of acts of violence (as opposed to natural disasters and so on) (Browne et al., 2015; Ponic et al., 2016). Using different language, Katula (2012) describes 'safe havens' as employment environments that address DFV and ensure employees are safe at work. An organisation that is trauma and violence informed is one that prioritises safety and the recovery trajectory for all people who interact with that organisation (Quadara, 2015). Such an organisation prioritises both psychological and physical safety, including through addressing vicarious trauma, responding to the diverse and sometimes complex needs of survivor staff and patients with a focus on autonomy and rebuilding a sense of control (Harms, 2015; Levy-Carrick et al., 2019). For example, a trauma and violence informed organisation aims to create warm and welcoming spaces that emphasise confidentiality, seek input from staff and patients about aspects of the system, especially in relation to safe and inclusive practices, takes a non-judgemental approach to everyone, attempts to foster connection, collaboration and trust between people and the organisation, and is clear and predictable

(Ponic et al., 2016). Table 15 presents my interpretation of the key principles of a trauma and violence informed organisational approach towards patients and staff for hospitals.

Table 15. Principles of trauma & violence informed care for hospitals

Principles	**Description**
Understanding	Foster an organisational culture that demonstrates understanding of trauma and violence and the complexity of human responses. Underpin interactions with staff and patients with this understanding. Train all staff on the associations between trauma and health impacts, including vicarious trauma.
Safety	Create an emotionally and physically safe health service in consultation with survivor staff and patients regarding inclusive and safe strategies. Confidentiality, compassion, a non-judgemental attitude, clarity, predictability and choice are central. Work towards minimising distress and maximising autonomy.
Trust & Transparency	Build and maintain relationships of trust among staff and between staff and patients. Understand that these relationships are an important vehicle towards health and recovery. To assist with this goal, organisational operations should be transparent.
Survivor voices	The voices of those with lived experience are integral to an organisation’s capacity to be sensitive to the needs and experiences of everyone using the system. Genuinely consulting survivors is critical for building trust, establishing safety, and harnessing resilience and growth.
Collaboration & Connection	Recognise the role everyone has in making a system trauma and violence informed. This includes recognition that recovery and growth can emerge from meaningful sharing of power and decision-making. Collaborate with specialist DFV and sexual assault services, strengthening pathways with those services.
Strengths	Focus on resilience, empowerment and hope, building on the strengths of staff and patients, rather than only responding to perceived deficits and problems. Work to meet women’s specific needs, understanding that each experience of trauma, and path of recovery after trauma, is unique.
Culture, history and gender sensitivity	Organisations need to offer culturally safe and gender responsive services, learning from the healing tradition of Aboriginal communities. A trauma and violence informed approach is aligned with the shift towards cultural safety – the principles of both put responsibility on systems to make policies and practices responsive and inclusive to optimise support for survivors.

Notes
The principles in this table are informed by the thoughtful work of Browne et al. (2015); Elliott et al. (2005); Harms (2015); Harris and Fallot (2001); Herman (1992); Ponic et al. (2016); Quadara (2015), and, Reeves (2015), among others.

Implementation of a trauma and violence informed framework in hospitals will be neither simple nor straightforward to achieve and will possibly require cultural change (Ponic et al., 2016). It will take time and demand a strategic approach to system-wide reform, and meaningful consultation with survivor staff will be central to its success. Learnings from other sectors such as mental health could assist. However, a need for change in the healthcare approach towards survivor staff is indicated by these findings. The goal of a trauma and violence informed approach for hospitals is that everyone who is part of the system - staff, patients, family members and the broader community – are better served through harm reduction and resiliency-building in pursuit of better health and healing (Bloom, 1997; Cocozza et al., 2005; Ponic et al., 2016).

8.7 FUTURE DIRECTIONS

Where this thesis finishes, there emerges avenues for useful future research. To address limitations in this study as well as investigate interesting topics indicated by it, further research could:

- Evaluate DFV workplace support programs in Victorian hospitals;
- Investigate the health, wellbeing and specialist service use of health professional survivors as well as the support and resource gaps identified by survivors;
- Investigate how vicarious trauma is impacted by DFV exposure;
- Explore the role of vicarious resilience and post-traumatic growth for health professional survivors.

In the quest towards better understanding of, and support for survivor health professionals, the Australian Nursing and Midwifery Federation (Vic Branch) have funded me to lead post-doctorate research with their nursing, midwifery and carer members for two years looking at the relationship between DFV and health, wellbeing, community service use, employment experience and support gaps (Appendix Z). This research is aimed at better support for all survivor nurses, midwives and carers, identifying needs at the level of the individual and the organisation.

8.8 CONCLUSIONS OF THIS THESIS

The conclusions of this thesis are that DFV is a common trauma in the lives of Australian health professional women, but rather than rendering survivors enduringly vulnerable, exposure appears to be positively associated with clinical care of survivor patients. This may indicate vicarious resilience and posttraumatic growth at work. Survivor staff and hospital managers agree that the hospital workplace has a vital role in responding to staff survivors with understanding, support and safety. A trauma and violence informed approach could guide support for staff and care of patients across the entire hospital system. Questions remain about the impact of DFV on health professionals’ health and employment experiences as well as the effectiveness of hospital workplace support programs. Better supporting clinicians is not only important for their recovery, or for the bottom line of the hospital, it may also enhance the extraordinary healing work that nurses, doctors and allied health professionals strive for every day with their patients.

There is a legacy of extraordinary contribution that has long been made by survivor professionals across different fields, in pursuit of both preventing violence and developing more informed and sensitive responses to survivors (Hague & Mullender, 2006). This transforming work has often occurred quietly, against the odds, over many years. It is time that survivor health professionals feel supported to come out of the shadows if they choose. To own their lived experience, ideas, hard work, care of others, needs and choices, confident that their healthcare workplace will value and understand them. To conclude my thesis, I salute the sentiments of the survivor health professional participant women below:

> *“What they* [survivors] *are experiencing doesn't make them an outcast and there are others out there who may be going through the same thing. I want to feel fully supported by my manager and the team I work with. I don’t want to feel judged by others for what I am going through, or I am less likely to come forward.”*

(Survivor health professional participant 505)

> *“Acknowledge this experience for staff. That is an important step in recognising and validating experience.”*

(Survivor health professional participant 341)

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Appendices

Appendix A: Search Strategy terms (Research questions three & four)

Table A: Search Strategy terms about organisational responses to survivor employees (research question three & four)

Keyword	**Concept 1**	**Concept 2**	**Concept 5**	**Concept 6**
Synonyms/Related words	Domestic violence	Health professional	Workplace	Program
	Family violence	Health personnel	Organi$ation	Policy/Policies (polic* NOT Police)
	Intimate partner violence	Health care provider	Hospital	Guideline
	Partner abuse	Health worker	Employer	Framework
	Spouse/spousal abuse (spous* abuse)	Helping professional		Strategy
	Battered/battering (batter*)	Nurse/nursing (nurs*)		Framework for program evaluation in public health
	Sexual abuse	Midwife/midwifery (midwif*)		
	Sexual assault	Doctor		
	Violence against women	Physician		
	Intimate/partner terror	Medical personnel		
	Intimate violence victim	Allied health personnel/professional		
	Child abuse	Psychologist		
	Dating violence	Physiotherapist		
		Occupational therap*		
		Clinician		

THE WOMEN AGAINST VIOLENCE PROJECT

THE UNIVERSITY OF
MELBOURNE

Hospital
Logo

THEWAVPROJECT

Thank you for opening the survey & taking the time to help us today.

Domestic violence and **sexual assault** are common, often hidden issues for women. The Women Against Violence (WAV) Project aims to build a better picture of how health professionals can provide care for women who experience domestic violence and sexual assault. We are also interested in how workplaces can better support staff who have experienced these types of violence.

The survey will take **10-15 minutes** to complete. You are free to complete the survey at work, or away from work, whatever is easiest for you. Your identity and responses will be entirely **anonymous** and **confidential**. The survey will ask you different questions about Violence Against Women (VAW), including training, the hospital environment, and your opinions and practice in this area. The survey will also ask about your personal experiences of domestic violence and sexual assault.

The WAV Project team is based at the Departments of General Practice and Social Work, The University of Melbourne. This is the PhD project of Liz McLindon, a Social Worker at the hospital's sexual assault service

If you become distressed at any point, or want to talk about how participation in the survey has affected you, a list of support services are listed at the end of this survey and available from this link: www.gp.unimelb.edu.au/wavproject/.

How to fill in the survey:

Please read all the questions carefully and follow the instructions throughout. Your answers will remain confidential. When you have completed the survey, please place it in the reply paid envelope enclosed and place in the mail.

There are no right or wrong answers; just put what is right for you. Don't try to over think your answers; your first response is usually the best. Some questions may seem similar to others; however we ask that you answer all questions to help ensure reliability.

Most of the questions can be answered by putting a tick in the box next to the answer that best applies to you. **Please tick only one box** per question, unless otherwise specified.

For example:

Are you?

Female	☑1
Male	☐2

If you wish to write further comments, please do so on the blank page at the end of the survey or attach extra pages if you wish.

Definition of Violence Against Women (VAW)
Please note that the hospital uses the United Nations definition of Violence Against Women (VAW), which includes physical, sexual and psychological violence, or the threat of such violence, by intimate partners, family members, or others. For the purposes of this survey, when you see the term "VAW", we mean domestic violence and/or sexual assault.

Thank you, your responses are valuable and appreciated.

Section A **Violence Against Women (VAW) Training**

Section A asks you to think about any Violence Against Women (VAW) training you have participated in.

A1. What do you estimate to be the total number of hours of VAW training you have attended? *By VAW training we mean training about domestic violence and/or sexual assault, including training you have received at the hospital, at other organisations, and at educational institutions, such as during your university education.*

☐ 0 hours *(If '0', please go to B1, page 5)*

☐ Less than 4 hours

☐ 4-8 hours

☐ More than 8 hours

A2. Below is a list of places that provide VAW training. For each of the following, please estimate how many hours of training you have received.

	None	**Less than 4 hours**	**4-8 hours**	**More than 8 hours**
The hospital	☐1	☐2	☐3	☐4
Another health service (e.g. another hospital, community health service, etc.)	☐1	☐2	☐3	☐4
A specialist VAW service external to the hospital (e.g. The Domestic Violence Resource Centre etc.)	☐1	☐2	☐3	☐4
An educational institution (e.g. at university as part of your studies, etc.)	☐1	☐2	☐3	☐4
Other *(please specify)* _______________________________________	☐1	☐2	☐3	☐4

Section B **Your Opinions**

Section B asks about your views regarding Violence Against Women (VAW) in your role as a health professional. Please remember that there are no right or wrong answers, we are seeking your opinion.

B1. For each of the following statements, please indicate your response on the scale from (1) "*Strongly disagree*" to (7) "*Strongly agree*".

Statements:	**1. Strongly disagree**	**2.**	**3.**	**4. Neither agree nor disagree**	**5.**	**6.**	**7. Strongly agree**
If a woman does not acknowledge the violence, there is very little that I can do to help	☐1	☐2	☐3	☐4	☐5	☐6	☐7
My workplace encourages me to respond to VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I can make appropriate referrals for women to VAW services within the community	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I do not have sufficient training to assist individuals in addressing situations of VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
If a woman remains in a relationship after repeated episodes of violence, they must accept responsibility for that violence	☐1	☐2	☐3	☐4	☐5	☐6	☐7
If a woman refuses to discuss the violence, staff can only treat the woman's injuries	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Women could leave abusive relationships if they wanted to	☐1	☐2	☐3	☐4	☐5	☐6	☐7

B1. ***Question continued from over the page.***

Statements:	1. Strongly disagree	2.	3.	4. Neither agree nor disagree	5.	6.	7. Strongly agree
Health professionals have a responsibility to ask all women they see about VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
My clinical setting allows me adequate time to respond to women who have experienced VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I have contacted services within the community to establish referrals for women who have experienced VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Asking about domestic violence and sexual assault is likely to offend those who are asked	☐1	☐2	☐3	☐4	☐5	☐6	☐7
There is adequate private space for me to care for/support a woman who has experienced VAW	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I am able to gather the necessary information to identify violence as the underlying cause of a woman's health issue (e.g. depression, bruises, fractures, etc.)	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Asking about and responding to VAW is not part of my role or scope of practice at the hospital	☐1	☐2	☐3	☐4	☐5	☐6	☐7

Section C **Your Practice & the Hospital Environment**

Section C asks you about the way you work and what you think about the hospital environment. Your answers to these questions will help us understand how health professionals experience their work.

C1. Have you worked directly with patients/clients in the last 6 months?

Yes ☐1

No ☐2 *(If 'no', please go to C6, page 10)*

C2. Thinking about the care and support you have provided women in the last 6 months, how comfortable did you feel asking about the following?

	Very uncomfortable	Uncomfortable	Comfortable	Very comfortable	Never asked
Current domestic violence	☐1	☐2	☐3	☐4	☐5
Past domestic violence	☐1	☐2	☐3	☐4	☐5
Current sexual assault	☐1	☐2	☐3	☐4	☐5
Past sexual assault	☐1	☐2	☐3	☐4	☐5

C3.This question asks you about actions you may have taken while working at the hospital in relation to Violence Against Women (VAW).

In the last 6 months, how often have you done the following?	**Never**	**Rarely** (1-3 times in last 6 mths)	**Occasionally** (Once/ mth)	**Frequently** (Once/ week)	**Quite frequently** (Daily)
Asked a woman about domestic violence and/or sexual assault	☐1	☐2	☐3	☐4	☐5
Provided information to a woman about VAW	☐1	☐2	☐3	☐4	☐5
Conducted a VAW risk assessment with a woman	☐1	☐2	☐3	☐4	☐5
Assisted a woman to develop a safety plan	☐1	☐2	☐3	☐4	☐5
Documented VAW in a woman's file	☐1	☐2	☐3	☐4	☐5
Used the hospital VAW Clinical Practice Guideline	☐1	☐2	☐3	☐4	☐5
Accessed information about VAW at the hospital Health Information Centre	☐1	☐2	☐3	☐4	☐5
Discussed a woman you thought had experienced violence at a team care meeting	☐1	☐2	☐3	☐4	☐5
Found the team care model at the hospital helpful for consultation and/or referral regarding VAW issues	☐1	☐2	☐3	☐4	☐5
Heard your current manager or team leader talk about the issue of VAW in relation to a woman	☐1	☐2	☐3	☐4	☐5
Discussed a woman you thought had experienced violence with your team leader or manager	☐1	☐2	☐3	☐4	☐5
Heard your current manager or team leader suggest that you or your colleague/s attend VAW training	☐1	☐2	☐3	☐4	☐5

C4. How many times in the last 6 months would you estimate that you have identified a new woman (e.g. patient/client) who has experienced domestic violence and/or sexual assault (VAW)? *For example, picked up a new case, uncovered ongoing violence, or received a disclosure of a past history of VAW.*

- ☐ None
- ☐ 1-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ 21 or more times

C5. Below is a list of services to which health professionals might refer patients/clients.

In the last 6 months, how often have you have referred a woman experiencing violence to one of these services?	**Never**	**Rarely** (1-3 times in last 6 mths)	**Occasionally** (Once/ mth)	**Frequently** (Once/ week)	**Quite frequently** (Daily)
The hospital social work service	☐1	☐2	☐3	☐4	☐5
A sexual assault service	☐1	☐2	☐3	☐4	☐5
A community domestic violence service (e.g. external to the hospital)	☐1	☐2	☐3	☐4	☐5
The hospital Alcohol and Drug Service	☐1	☐2	☐3	☐4	☐5
The hospital Pregnancy Advisory Service	☐1	☐2	☐3	☐4	☐5
The hospital mental health service	☐1	☐2	☐3	☐4	☐5
The hospital Aboriginal Health Business Unit	☐1	☐2	☐3	☐4	☐5
Community Legal Service outpost at the hospital	☐1	☐2	☐3	☐4	☐5

C6. In the last 6 months, have you noticed any of the following violence against women (VAW) resource materials displayed at the hospital?

	Yes	No
Posters	☐1	☐2
Staff badges	☐1	☐2
Pamphlets	☐1	☐2

Thank you, we appreciate your time, please continue.

Section D **Your Relationships**

This section asks you some personal questions about your own experience of domestic violence and/or sexual assault. A reminder that your responses are completely confidential. We know that these are common issues, and that your personal experiences may impact on your experience of working at the hospital. Please refer to the list of resources at the end of this survey if you would like any support.

By '*adult intimate relationship*' we mean partner, husband/wife or boy/girl friend for longer than 1 month.

D1. **a.** **Have you ever been in an adult intimate relationship?**
(since you were 16 years of age)
Yes ☐1 No ☐2 *(If 'no', please go to D4, page 14)*

b. **Have you been in an adult intimate relationship in the last 12 months?**
Yes ☐1 No ☐2

c. **Are you currently in an intimate relationship?**
Yes ☐1 No ☐2

D2. **a.** **Are you currently afraid of your partner or ex-partner?**
Yes ☐1 No ☐2

b. **Have you been afraid of any partner or ex-partner in the last 12 months?**
Yes ☐1 No ☐2

c. **Have you *ever* been afraid of any partner or ex-partner?**
Yes ☐1 No ☐2

D3. On the next two pages, we would like to know if you have ever experienced any of the actions listed below by a partner or ex-partner *(since you were 16 years of age)?*

On each line please tell us two things:
1) How often the actions happened in the last 12 months? ***And***
2) Whether the actions happened more than 12 months ago? *(Please leave this final column blank if they did not happen more than 12 months ago)*

My partner or ex-partner:	**Never** in last 12 mths	**Only once** in last 12 mths	**Several times** in last 12 mths	**Once/ month** in last 12 mths	**Once/ week** in last 12 mths	**Daily** in last 12 mths	**Happened *MORE THAN* 12 mths ago**
Told me that I wasn't good enough	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Kept me from medical care	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Followed me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Tried to turn my family, friends and/or children against me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Locked me in the bedroom	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Slapped me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Forced me to have sex	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Told me that I was ugly	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Tried to keep me from seeing or talking to my family	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Threw me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Hung around outside my house	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Blamed me for causing their violent behaviour	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Harassed me over the telephone	☐1	☐2	☐3	☐4	☐5	☐6	☐7

D3. ***Question continued.***

My partner or ex-partner:	**Never** in last 12 mths	**Only once** in last 12 mths	**Several times** in last 12 mths	**Once/ month** in last 12 mths	**Once/ week** in last 12 mths	**Daily** in last 12 mths	**Happened *MORE THAN* 12 mths ago**
Shook me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Tried to force me to have sex	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Harassed me at work	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Pushed, grabbed or shoved me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Used a knife or gun or other weapon	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Became upset if dinner/housework was not done when they thought it should be	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Told me that I was crazy	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Told me that no one would ever want me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Took my wallet and left me stranded	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Hit or tried to hit me with something	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Did not want me to socialise with my female friends	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Put foreign objects in my vagina/anus	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Refused to let me work outside the home	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Kicked me, bit me or hit me with a fist	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Tried to convince my friends, family or children that I was crazy	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Told me that I was stupid	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Beat me up	☐1	☐2	☐3	☐4	☐5	☐6	☐7

D4. Have you ever experienced violence or abuse from a family member? (e.g. someone who is not your partner, like a parent, uncle, in-law, sibling).

Yes ☐1 No ☐2

D5. Growing up, was there ever violence or abuse in your home between your parents?

Yes ☐1 No ☐2

D6. Have you ever experienced violence or abuse from somebody other than a partner or family member?

Yes ☐1 No ☐2

If yes, please describe:

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D7. How strongly do you agree or disagree with the following statements about working with patients/clients who might have experienced domestic violence and/or sexual assault (VAW)?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A – I am not in clinical practice
I have wanted to avoid raising the issue of VAW with my patients/clients	☐1	☐2	☐3	☐4	☐5	☐6
I have found it upsetting to talk about the issue of VAW with my patients/clients	☐1	☐2	☐3	☐4	☐5	☐6
I have been very aware of the issue of VAW with my patients/clients	☐1	☐2	☐3	☐4	☐5	☐6
I have tried to go the extra mile to respond to the issue of VAW with my patients/clients	☐1	☐2	☐3	☐4	☐5	☐6

D8. As a result of domestic violence and/or sexual assault that you have experienced, have any of the following been an issue during your entire employment history? *Please tick all that apply.*

☐ N/A – I have not had any abusive experiences
☐ Took unpaid time off work
☐ Took paid time off work (e.g. sick leave, special leave)
☐ Was late for work
☐ Work performance was affected by being distracted/tired/unwell
☐ Was stopped from going to work by partner or ex-partner
☐ Was stalked/harassed while at work by partner or ex-partner
☐ Was affected by depression while at work
☐ Was affected by anxiety/fear while at work
☐ An injury affected my ability to work
☐ Attended work to avoid violence at home
☐ Other *(please specify)*____

Section E **Workplace Support**

Section E asks you for your ideas about support and resources for staff at your workplace.

E1. How helpful do you think the following kinds of support would be for staff who are dealing with personal experiences of domestic violence and/or sexual assault (VAW)?

	Very unhelpful	Unhelpful	Neither helpful nor unhelpful	Helpful	Very helpful	I don't know
Special domestic violence leave in addition to current entitlements (e.g. extra leave hours)	☐1	☐2	☐3	☐4	☐5	☐6
Special domestic violence leave within current entitlements (e.g. no extra leave hours)	☐1	☐2	☐3	☐4	☐5	☐6
Specialist VAW Employee Assistance Program (EAP) counsellors	☐1	☐2	☐3	☐4	☐5	☐6
Managers at the hospital trained to respond to VAW issues	☐1	☐2	☐3	☐4	☐5	☐6

E2. Are there any additional supports you would like to see in place at the hospital for staff who are dealing with personal experiences of domestic violence and/or sexual assault?

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E3. What things could the hospital do to support you in your work dealing with women (patients/clients) who have experienced VAW?

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Section F **Information about you**

This last section asks some questions about you, which will help us draw meaning from the data. Please remember that all survey responses will be de-identified and entirely confidential. Only aggregate data on large groups of respondents will be reported.

F1. Are you?

Female ☐1
Male ☐2

F2. Which one of the following age groups do you fit into?

Less than 30 years ☐1
30-39 years ☐2
40-49 years ☐3
50-59 years ☐4
60+ years ☐5

F3. Which of the following professions does your position best align with?

Midwifery ☐1
Nursing ☐2
Medical (e.g. Registrars, Consultants) ☐3
Allied Health (e.g. Physiotherapists, Social Workers) ☐4
Medical Support (e.g. Imaging, Pharmacy) ☐5
Other *(please specify)*_______________________________________ ☐6

Nearly finished, only 4 quick questions to go!

F4. In which clinical area of the hospital do you typically work?
(Please tick one)

Maternity ☐ 1
Neonatal Services ☐ 2
Gynaecology, Oncology and Perioperative ☐ 3
Women's health ☐ 4
Other (*please specify*):________________________________ ☐ 5

F5. How many years have you worked at the hospital?

Less than 1 year ☐ 1
1-2 years ☐ 2
3-4 years ☐ 3
5-9 years ☐ 4
10-19 years ☐ 5
20-29 years ☐ 6
30+ years ☐ 7

F6 How many years have you worked as a health professional?

Less than 1 year ☐ 1
1-2 years ☐ 2
3-4 years ☐ 3
5-9 years ☐ 4
10-19 years ☐ 5
20-29 years ☐ 6
30+ years ☐ 7

F7. In your current role at the hospital do you supervise staff?

Yes ☐ 1
No ☐ 2

Final Comments

Please add any extra comments that you wish to make about any issue raised in the survey:

Thank you very much, you have now completed the survey!

Thank you very much for the time and effort you have taken to complete the survey. We know you are busy so we really appreciate it.

Please use the reply paid envelope (no stamp required) to send the survey back to us. If no envelope was enclosed with the survey, or you have mislaid it, please call us on (03) 8344 4102 and we will send you another one.

If you wish to talk to someone about any of the issues raised in this survey, you can contact one of the services listed below.

Violence Against Women support services:

- Women's Domestic Violence Crisis Line (Ph: 9322 3555)
- Sexual Assault Crisis Line (Ph: 1800 806 292)
- Lifeline (Ph: 13 11 14)
- Employee Assistance Program (Ph: 1300 360 364)
- 1800RESPECT (Ph: 1800 737 732, www.1800respect.org.au/)

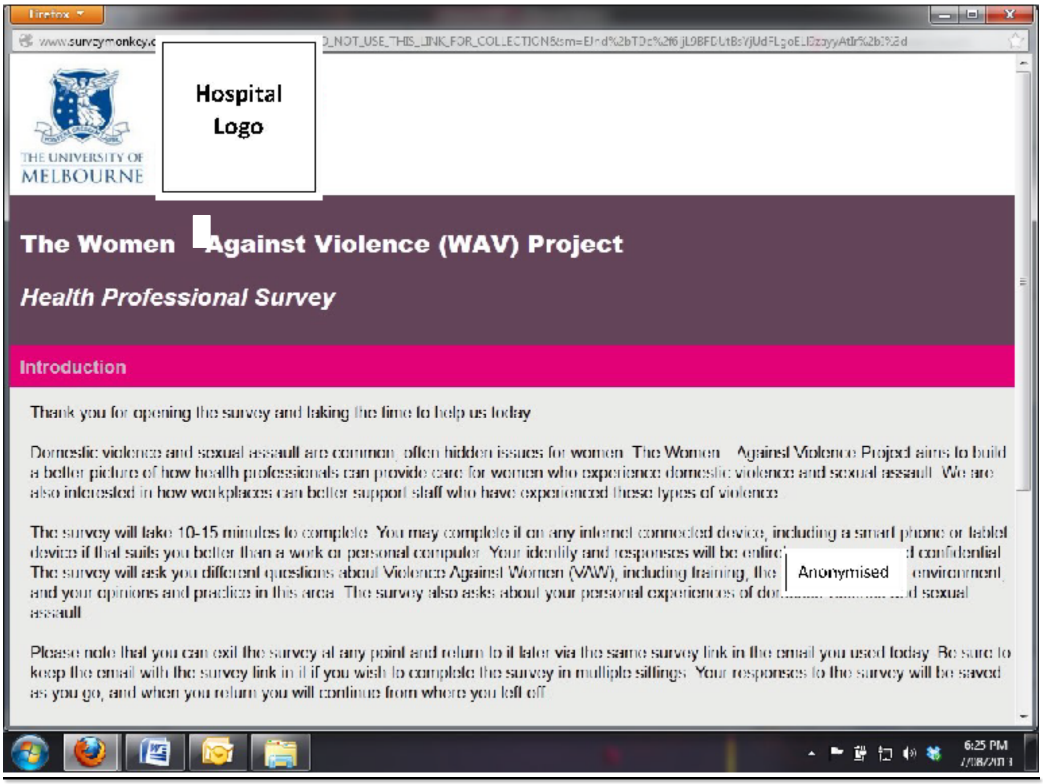
Many thanks,
The WAV Project team.

This questionnaire includes ©PREMIS, Short, 2006 and ©CAS, Hegarty, 1999.

The
Women
Against
Violence
Project

Health Professional Survey

Appendix C: Online survey grab



The Women Against Violence (WAV) Project

Health Professional Survey

Introduction

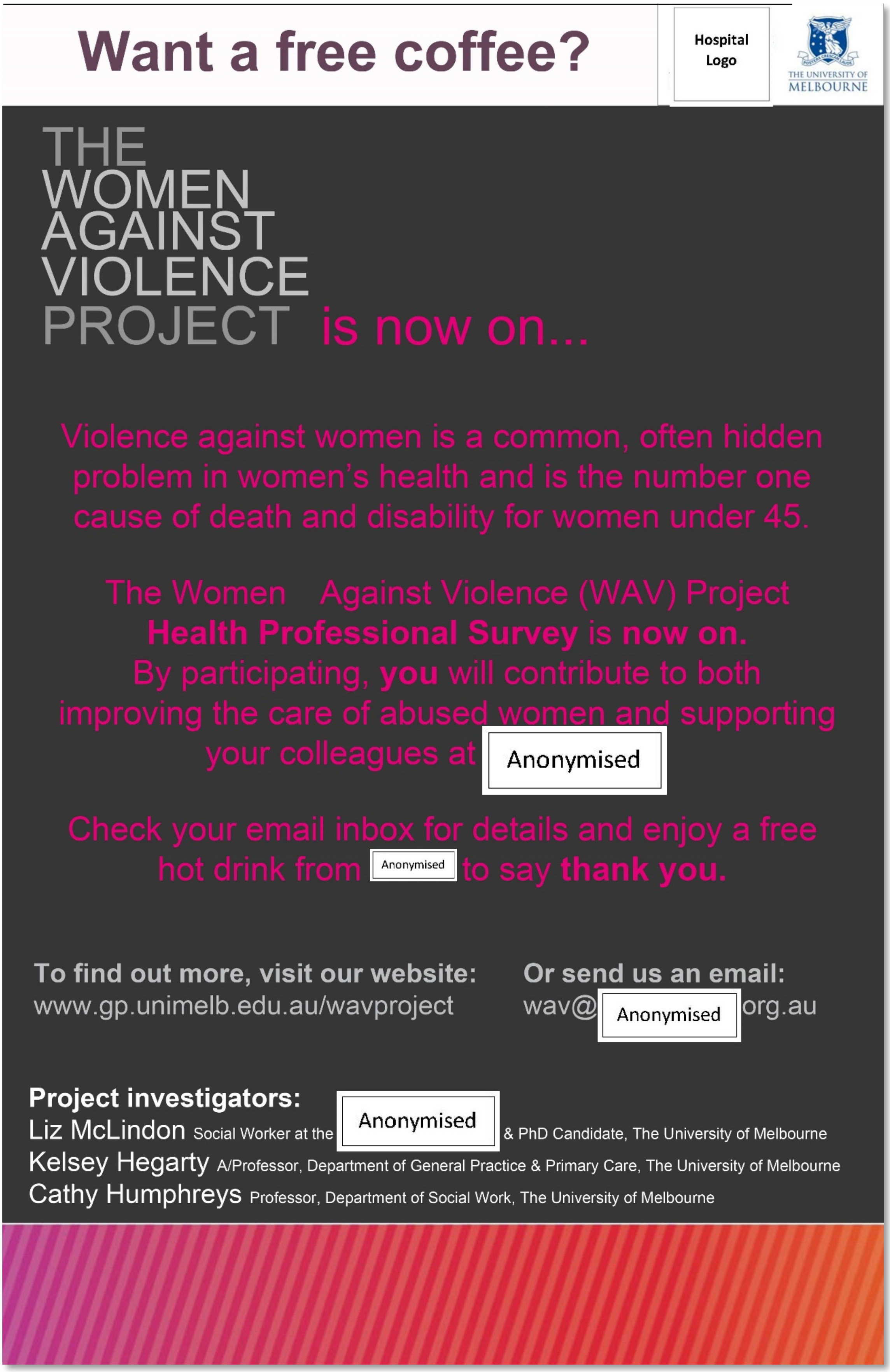
Thank you for opening the survey and taking the time to help us today.

Domestic violence and sexual assault are common, often hidden issues for women. The Women Against Violence Project aims to build a better picture of how health professionals can provide care for women who experience domestic violence and sexual assault. We are also interested in how workplaces can better support staff who have experienced these types of violence.

The survey will take 10-15 minutes to complete. You may complete it on any internet connected device, including a smart phone or tablet device if that suits you better than a work or personal computer. Your identity and responses will be entire d confidential. The survey will ask you different questions about Violence Against Women (VAW), including training, the Anonymised environment, and your opinions and practice in this area. The survey also asks about your personal experiences of do d sexual assault.

Please note that you can exit the survey at any point and return to it later via the same survey link in the email you used today. Be sure to keep the email with the survey link in it if you wish to complete the survey in multiple sittings. Your responses to the survey will be saved as you go, and when you return you will continue from where you left off.

Appendix D. Project poster



Want a free coffee?

Hospital Logo

THE UNIVERSITY OF MELBOURNE

THE
WOMEN
AGAINST
VIOLENCE
PROJECT is now on…

Violence against women is a common, often hidden problem in women's health and is the number one cause of death and disability for women under 45.

The Women Against Violence (WAV) Project **Health Professional Survey** is **now on.**
By participating, **you** will contribute to both improving the care of abused women and supporting your colleagues at Anonymised

Check your email inbox for details and enjoy a free hot drink from Anonymised to say **thank you.**

To find out more, visit our website:
www.gp.unimelb.edu.au/wavproject

Or send us an email:
wav@Anonymised org.au

Project investigators:
Liz McLindon Social Worker at the Anonymised & PhD Candidate, The University of Melbourne
Kelsey Hegarty A/Professor, Department of General Practice & Primary Care, The University of Melbourne
Cathy Humphreys Professor, Department of Social Work, The University of Melbourne

Appendix E. Primer email

Subject: Please support The WAV Project
From: Acting Chief Executive

Dear [FirstName],

Violence against women is a common, often hidden problem in women's health and is the number one cause of death and disability for women under 45.

This is an invitation for you to contribute to both improving the care of abused women and supporting your colleagues at our hospital.

We are asking for your help!

At the hospital we have a Violence Against Women 'Strategy' aimed at addressing the needs of women and the needs of the multidisciplinary staff who provide support and treatment.

The Women Against Violence (WAV) Project seeks to understand the experience of the staff who work within this environment and how staff can be better supported as they provide care for women who have experienced domestic violence and sexual assault. Health professionals have a core role to play in effective intervention, which is crucial to positive outcomes for women. We want to make sure our whole-of-hospital approach to violence against women is an effective intervention and that our colleagues are supported in providing care.

In a few days the project team will send you an email invitation to complete a 10-15 minute online survey.

The hospital Executive fully supports The WAV Project and recognises the value it should add to research in the area of violence against women, leading to improvements for our staff and patients. I urge you to take the time to participate.

The WAV Project team are:
Liz McLindon, Social Worker at __________ and PhD Candidate at University of Melbourne
Kelsey Hegarty, A/Professor of General Practice and Primary Health Care, The University of Melbourne
Cathy Humphreys, Professor of Social Work, The University of Melbourne

Sincerely,

Chief Executive Officer (Acting)
On behalf of The WAV Project team

Appendix F. Introductory email (Online survey)

Subject: Invitation to participate in The WAV Project
From: wav@thehospital.org.au
Attachment: Plain Language Statement

Dear [FirstName],

The WAV Project Health Professional survey is here!

The WAV Project is seeking to ensure our whole-of-hospital approach to violence against women (VAW) is an effective intervention for women, and that our colleagues are supported in providing care to women who have experienced violence.

We are asking all health professionals at the hospital - including midwives, nurses, doctors and allied health professionals - to complete a survey about VAW and their role at the hospital. VAW is a major public health issue and is associated with substantial levels of illness and disability. Effective intervention is the role of every clinician at the hospital in our whole-of-hospital approach.

We appreciate that you are extremely busy; VAW is a priority issue for the hospital, as reflected in the strategic plan, because it affects both women and staff. As a small token of our thanks we have a FREE coffee/drink voucher for you! You may access this voucher here:
http://www.gp.unimelb.edu.au/wavproject/voucher.html

Please help us by spending 10-15 minutes completing the survey. Responses to the survey are strictly confidential. You can complete the survey on any internet connected device, including a smart phone or tablet device if that suits you better than a work or personal computer. To find out more about the project and read the plain language statement, please visit the Project website:
http://www.gp.unimelb.edu.au/wavproject/

To start the survey click here:
[SurveyLink]

The hospital Executive fully supports this project and recognises the value it may add to research in the area of violence against women, leading to improvements for our staff and the women who access our services.

Sincerely,
The WAV Project Team
Liz McLindon, A/Professor Kelsey Hegarty and Professor Cathy Humphreys

Appendix G. Plain Language Statement (Online survey)

THEWAVPROJECT

The Women Against Violence (WAV) Project

Plain Language Statement

Introduction

Violence Against Women (VAW) includes physical, sexual and psychological violence by intimate partners or others and is a major determinant of women and children's health. Nearly 1 in 3 Australian women experience physical violence and almost 1 in 5 women experience sexual violence over their lifetime (ABS, 2005). In Victoria, intimate partner violence is the leading contributor to premature death, illness and injury for women of childbearing age (VicHealth, 2004).

At the hospital, we have a Violence Against Women Strategy aimed at addressing the needs of women who have experienced violence, as well as the needs of the multidisciplinary health professionals who provide support and treatment. An evaluation of this Strategy from the perspective of women using the hospital service and the staff who work within it has never been undertaken. Evaluations of health system responses to VAW have been extremely limited, with none looking at the personal experiences of staff.

What is The WAV Project?

We have called this PhD project ***The Women Against Violence (WAV) Project:*** *Experiences of women and staff in a complex health setting*. The Project aims to evaluate aspects of the hospital VAW Strategy. This part of the project involves a survey for clinical health professionals at the hospital – midwives, doctors, allied health professionals, nurses – YOU!

Who are the researchers?

We have practitioner Social Work and General Practice backgrounds and work at the University of Melbourne.

Ms Elizabeth McLindon
Social Worker at the hospital sexual assault service & PhD Candidate
Associate Professor Kelsey Hegarty
General Practice & Primary Health Care Academic Centre
Professor Cathy Humphreys
Department of Social Work

Will there be any benefits to doing the study?
As a result of this study we hope to make improvements for both women who have experienced violence and staff at the hospital. The outcomes of **The WAV Project** will be relevant locally, nationally and internationally.

As a small token of our thanks we have a free coffee/drink voucher for you. You may access this voucher via The WAV Project website http://www.gp.unimelb.edu.au/wavproject/.

What will I be asked to do?
You will be asked to complete a short online questionnaire, which will take about 10-15 minutes. A link has been sent to your hospital email. The survey can be accessed from any device with an internet connection, including a smart phone or tablet device. You are free to complete the survey at work, or away from work, whatever is easiest for you.

The survey will ask you different questions about VAW, including training, the hospital environment, opinions and practice in relation to VAW. The survey will also ask you about your personal experiences of violence. This section contains sensitive questions and is your choice to complete.

If you choose not to complete this section, we still encourage you to complete the rest of the survey, as your responses to the other sections are still useful.

Why have I been selected to participate?
You are being sent this email because you are a health professional at the hospital. An administrator at the hospital is sending out the survey via email to all clinicians on behalf of the researchers.

By utilising an independent administrator from the hospital, outside the research team, we can be sure that both the research team and the hospital is never able to link survey responses to individuals. It is your choice whether to participate.

How will my confidentiality be protected?
Any survey data you provide will be treated as **confidential** and your identity will be anonymous to the researchers. Maintaining confidentiality is very important to the researchers.

An identification number will be used on returned surveys so the survey administrator can track who has and has not returned the survey, and target reminders only to those that have not responded. By doing this we can ensure that we do not repeatedly remind staff who have already completed the survey to respond. Only the survey administrator will have the key to the identification number, which will never be linked to survey results.

You may withdraw from the project at any stage, and if requested, we will destroy any unprocessed data. Any publications or presentations to arise from this research will contain aggregate data only, so participants will not be able to be identified.

How will the survey data be stored?
At the end of the survey the administrator will extract the de-identified data and send it to the researchers. After this all online survey data will be permanently deleted.

All de-identified survey results from participating health professionals will be kept secure, in locked storage at the Department of General Practice, The University of Melbourne. The research data and records will be kept for a minimum of five years after publication, or public release of the research. It will then be destroyed in accordance with the University guidelines.

How will I find out the results of The WAV Project?
Upon completion of **The WAV Project,** a report of the findings will be presented to the hospital and this will be available to you. The Communications Department will announce this across the hospital at that time. In addition, any publications or conference presentations to emerge from the findings will also be announced to all staff by the Communications Department.

Who can I talk to about the project if I have concerns or experience distress in relation to any of the issues raised?
If you have any questions about the project, please contact:

- Liz McLindon (03) 8344 4102
- Kelsey Hegarty (03) 8344 7276

If you want to talk about any concerns about your own well-being you can contact the:

- Employee Assistance Program 1300 360 364
- 1800RESPECT 1800 737 732

You will find a full list of resources at the end of the survey which you may like to contact, or you can visit www.gp.unimelb.edu.au/wavproject/resources.html.

If you have any complaints or concerns about the conduct of this project, please contact the hospital Human Research Ethics Committee Secretariat on (03) ___________.

How do I agree to participate?
If you would like to participate, please complete the online survey attached to this email. Through taking the time to complete this survey, your consent will be implied.

Thank you very much
for taking the time to read this information.

Appendix H. Reminder email 1

Subject: Want a free coffee? Reminder to participate in the WAV Project!
From: wav@thehospital.org.au

Dear [FirstName],

Over the last few weeks, you would have heard about The Women Against Violence (WAV) Project. This is a friendly reminder to please complete the Health Professional Survey.

Click on this link to complete the survey today:
[SurveyLink]

As a small token of our thanks we have a free coffee/drink voucher for you. You can access this voucher here:
http://www.gp.unimelb.edu.au/wavproject/voucher.html

You can learn more about The WAV Project here:
http://www.gp.unimelb.edu.au/wavproject/

Confidentiality is very important to the project team. Your responses to the survey will never be identifiable.

We sincerely appreciate your time and effort.

The WAV Project Team
Liz McLindon, A/Professor Kelsey Hegarty and Professor Cathy Humphreys

Appendix I. Reminder email 2

Subject: We need to hear from you! Reminder to participate in the WAV Project
From: wav@thehospital.org.au

Dear [FirstName],

As you may have heard, The WAV Project is now on. We have already had over 300 clinical hospital staff complete the survey, which is fantastic. We want you to join this group so that we can confidently report on our findings. We are hoping to grow the number of our staff who have had their voices heard to 600.

Click on this link to complete the survey today:
[SurveyLink]

By participating in this survey, you will be part of an Australian first project that aims to understand women’s experience of domestic violence and sexual assault and improve the support and safety available to them in its aftermath.

In a small gesture of our huge appreciation, we have a free coffee voucher for you. You can access this voucher here:
http://www.gp.unimelb.edu.au/wavproject/voucher.html

Learn more about The WAV Project click here:
http://www.gp.unimelb.edu.au/wavproject/ , and please note that confidentiality is very important to the project team, your responses to the survey will never be identifiable.

Sincerely,

The WAV Project Team
Liz McLindon, A/Professor Kelsey Hegarty and Professor Cathy Humphreys

Appendix J. Manager email

Subject: Managers help needed with The WAV Project
To: Clinical hospital managers
From: wav@thehospital.org.au

Dear [Manager FirstName],

I am writing about The WAV Project Health Professional survey that is currently underway. This is important research that the hospital and The University of Melbourne are doing in the area of domestic violence and sexual assault, and it should lead to improvements for our staff and patients.

However, the project team are currently in jeopardy of not reaching the response rate they require for the findings to be statistically significant. As a manager, we need your help – please encourage your staff to participate and allow your staff time to do this.

Please note that confidentiality is very important to the project team and survey responses will never be identifiable. Should staff want to participate, they can find a link to the survey sent to them via their hospital email Thursday 8 August, and a reminder sent Thursday 22 August. Another link will be sent in a reminder email in a few days. If staff cannot find this email link, they can contact wav@thehospital.org.au and a project administrator will send them another one.

We sincerely appreciate your time and effort.

Sincerely,

____
Chief Executive (Acting)

Appendix K. Cover letter (Paper survey)

THEWAVPROJECT

Dear [FirstName],

This is your last chance to participate in **The WAV Project** by completing the Health Professional survey!

Over the past few months, you have been sent information about this project and invitations to complete the Health Professional survey via your hospital email inbox. We appreciate that you are very busy; we are now sending you a final copy of the survey in paper format in case it will make it easier for you to participate this way.

We need your help and expertise: this survey has been sent to all health professionals at the hospital, including midwives, nurses, doctors and allied health professionals. We thank the many clinicians who have already completed the survey online; however, we still need more to reach our target response rate. It is only with the help of clinicians like you that we can be sure the experiences and needs of all health professionals at the hospital are represented and this project can have an impact. Please complete the survey today and send it back to us in the reply-paid envelope enclosed. The survey will take 10-15 minutes to complete and participation is voluntary.

As a very small token of our very big thanks, enclosed is a free coffee/hot drink voucher for you.

The WAV Project is investigating the hospital approach to Violence Against Women. It is looking at both the impact for women who have experienced domestic violence and/or sexual assault, as well as the clinicians who provide treatment and support. Violence against women is responsible for more preventable ill health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including obesity and smoking. We want to improve the experience for women who access health services after violence and for the staff who work within those services.

The hospital Executive fully endorses this project led by the University of Melbourne. Responses to the survey are strictly confidential. To find out more about the project, please read the plain language statement enclosed and/or visit **The WAV Project** website: www.gp.unimelb.edu.au/wavproject

Thank you very much for taking the time to read this letter. Your response to the survey will be valuable and appreciated.

Sincerely,

The WAV Project Team
Ms Liz McLindon, Professor Kelsey Hegarty and Professor Cathy Humphreys

THEWAVPROJECT

The Women Against Violence (WAV) Project

Plain Language Statement

Introduction

Violence Against Women (VAW) includes physical, sexual and psychological violence by intimate partners or others, and is a major determinant of women and children's health. Nearly 1 in 3 Australian women experience physical violence and almost 1 in 5 women experience sexual violence over their lifetime (ABS, 2005). In Victoria, intimate partner violence is the leading contributor to premature death, illness and injury for women of childbearing age (VicHealth, 2004).

At the hospital, we have a Violence Against Women Strategy aimed at addressing the needs of women who have experienced violence, as well as the needs of the multidisciplinary health professionals who provide support and treatment. An evaluation of this Strategy from the perspective of women using the hospital service and the staff who work within it has never been undertaken. Evaluations of health system responses to VAW have been extremely limited, with none looking at the personal experiences of staff.

What is The WAV Project?

We have called this PhD project ***The Women Against Violence (WAV) Project:*** *Experiences of women and staff in a complex health setting*. The Project aims to evaluate the hospital's VAW Strategy. This part of the project involves a survey of clinical health professionals at the hospital – midwives, doctors, allied health professionals, nurses – YOU! You can find out more by visiting the project website: www.gp.unimelb.edu.au/wavproject

What will I be asked to do?

You will be asked to complete a short questionnaire which will take about 10-15 minutes. You are free to complete the survey at work, or away from work, whatever is easiest for you. The survey will ask you different questions about VAW, including training, the hospital environment, opinions and practice. The survey will also ask you about your personal experiences of violence. This section contains sensitive questions and is optional to complete. If you choose not to complete this section, we still encourage you to complete the rest of the survey, as your responses to the other sections are still useful. Once you have completed the survey, we ask that you place it in the reply-paid envelope enclosed and put it in the mail.

Who are the researchers?

We have clinical and academic Social Work and General Practice backgrounds:
Ms Elizabeth McLindon: Social Worker at the hospital Centre Against Sexual Assault & PhD Candidate at The University of Melbourne
Professor Kelsey Hegarty: General Practice & Primary Health Care Academic Centre, The University of Melbourne
Professor Cathy Humphreys: Department of Social Work, The University of Melbourne.

Will there be any benefits to doing the study?

As a result of this study we hope to make improvements for both women who have experienced violence and staff at the hospital. The outcomes of **The WAV Project** will be relevant locally, nationally and internationally.

As a small token of our thanks we have a free coffee/hot drink voucher for you enclosed. Just take the voucher to the hospital café get your hot drink. If you did not receive a voucher with your survey or you have misplaced it, please let us know via email (wav@thehospital.org.au) and we will send you another one.

Why have I been selected to participate?

You are being sent this survey because you are a health professional at the hospital. If you think you may have been sent this survey in error, please contact us via email: wav@thehospital.org.au.

How will my confidentiality be protected?

Any survey data you provide will be treated as **confidential** and your identity will be anonymous to the researchers. Maintaining confidentiality is very important to us. To protect your confidentiality further, we have not included an identification number on the survey. However, this means that you can only withdraw from the project prior to sending your survey back to us, since if you wish to withdraw from the project after sending us your survey, we will not be able to identify it to withdraw it from the project. Any publications or presentations to arise from this research will contain aggregate data only, so participants will not be able to be identified.

How will the survey data be stored?

All de-identified survey results from participating health professionals will be kept secure, in locked storage at the Department of General Practice, The University of Melbourne. The research data and records will be kept for a minimum of five years after publication, or public release of the research. They will then be destroyed in accordance with the University guidelines. If you choose to participate in a follow up interview or focus group and fill in the *Expression of Interest* on the final page of the survey, this page will be removed and stored separately from your completed survey in accordance with the same secure storage guidelines above.

How will I find out the results of The WAV Project?

Upon completion of **The WAV Project**, a report of the findings will be presented to the hospital and this will be made available to you. The Communications Department will announce this across the hospital at that time. In addition, any publications or conference presentations to emerge from the findings will also be announced to all staff by the Communications Department.

Who can I talk to about the project if I have concerns or experience distress in relation to any of the issues raised?

If you want to talk about any concerns you have about your own well-being, you can contact:

- Employee Assistance Program 1300 360 364
- 1800RESPECT 1800 737 732

You will find a full list of resources at the back of your survey and you can also visit: www.gp.unimelb.edu.au/wavproject/resources.html.

If you have any questions about the project, please contact one of the researchers:

- Liz McLindon (03) 8344 4102
- Kelsey Hegarty (03) 8344 7276
- Cathy Humphreys (03) 8344 9427
- If you have any complaints or concerns about the conduct of this project, please contact the hospital Human Research Ethics Committee Secretariat on (03) 8345 3720.

How do I agree to participate?

Through taking the time to complete this survey and sending it back to us, your consent will be implied.

Thank you very much for taking this time to read this information.

Appendix M. Logical checks

Logical check 1 rule
If participant selected ‘0’ hours to training question (A1) then question A2 should have been left blank. If A2 is not blank, and 1-8+ hrs was selected, it will be assumed that A1 response is incorrect and will be altered to “yes”.

Logical check 2 rule
If participant selected “no” to clinical work question (C1), however in looking through their responses to subsequent clinical questions (C3) it appears that they had engaged in clinical work in the last 6-months, then it will be assumed they answered “no” to question C1 incorrectly and their response changed accordingly.

Logical check 3 rule
If a participant has never been in a relationship (i.e. answered “no” to question D1), then the other relationship and afraid variables should be blank. If not, it will be assumed that D1 response was incorrect and “no” altered to “yes”.

Logical check 4 rule
If a participant selected more than one frequency item on the 12-month Composite Abuse Scale (D3), keep the highest frequency and disregard other frequencies selected.

Logical check 5 rule
Participants who identify that they are under 30 years old (F2), should select years working as HP and years at the recruiting hospital of not more than 5-9 (F5).

Logical check 6 rule
Participants who identify that they have had 30+ years of experience working as a health professional should be 50+ years old (F6).

Appendix N. Univariate analysis (example)

DFV Training variables (Survey items A1, A2)

Variable	N	Mean	Median	Std. Dev.	Min.	Max.	Variance	Skew	Level of measurement	Missing
train_hr	526	1.22	1	1.08	0	3	1.18	0.48	Ordinal	1, <5%
train_spechosp	365	1.07	1	0.92	0	3	0.85	0.56	Ordinal	2, <5%
train_hosp	362	0.52	0	0.86	0	3	0.74	1.64	Ordinal	2, <5%
train_spec	364	0.33	0	0.84	0	3	0.71	2.43 [1]	Ordinal	3, <5%
train_edu	365	0.88	1	1.01	0	3	1.02	0.92	Ordinal	2, <5%
train_other	365	0.16	0	0.59	0	3	0.35	3.97 [2]	Ordinal	2, <5%

Notes:

[1] **Skew** is excessive, although just under 2.5, so should not be an issue

[2] Skew is excessive although explained by participants only completing if relevant. Variable does not need to undergo further analysis

Appendix O. Clinical care binary variables

- 1+ days of professional DFV training;
- Having felt comfortable/very comfortable asking about DFV and sexual assault;
- Disagreeing/strongly disagreeing that they had wanted to avoid raising DFV with their patients or had found it upsetting to talk about;
- Agreeing/strongly agreeing they had an awareness of DFV and had attempted to go the extra mile with their patients;
- Had at least once inquired about DFV with a patient;
- Had identified at least one new survivor patient;
- Had at least once conducted a risk assessment, safety plan, documented DFV in the medical record, utilised the hospital DFV clinical practice guideline, accessed DFV information; discussed DFV at a team meeting or with a manager, referred a survivor patient to an interval hospital or external DFV support service

Appendix P. Introductory email (Interviews)

Subject: Meeting to discuss staff issues re: violence against women
From: wav@thehospital.org.au
Attachment: Plain Language Statement

Dear [FirstName],

As you may be aware, I am doing a PhD project titled: ***The WAV (Women Against Violence) Project**,* and I recently conducted a whole staff survey about the personal and professional issue of domestic violence and sexual assault. Five hundred and twenty seven of our permanent clinical staff took part and they had many things to say about how violence has affected them in their work, what sorts of things would help them in the workplace and what it is like to work with patients who are affected by domestic violence and/or sexual assault.

The second phase of this project involves talking with ‘key stakeholders’ about their views of the violence against women agenda at the hospital, and specifically, the role of a hospital in responding to staff who may have experienced violence. I would like to talk to you further about some of these issues in your role as a clinical director/manager/Union official, by scheduling a 30-60 minute meeting with you. I am especially interested in doing this since the results of this study will inform the hospital Workforce Strategy, and I believe that you will have an important perspective to incorporate.

Please find additional information attached, and please note that this project has received ethical approval by both the hospital and The University of Melbourne. I look forward to hearing from you via return email, or if you would like to talk about this further, please contact my mobile on 04___________.

Sincerely,

Liz McLindon
PhD Candidate | The WAV Project | The Department of General Practice | The University of Melbourne
WAV website: www.gp.unimelb.edu.au/wavproject

Project Supervisors
Professor Kelsey Hegarty | Department of General Practice | Professor Cathy Humphreys | Department of Social Work | The University of Melbourne

Appendix Q. Plain Language Statement (Interviews)

THEWAVPROJECT

The Women Against Violence (WAV) Project

Plain Language Statement

Introduction

Violence Against Women (VAW) includes physical, sexual and psychological violence by intimate partners or others and is a major determinant of women and children’s health. Nearly 1 in 3 Australian women experience physical violence and almost 1 in 5 women experience sexual violence over their lifetime (ABS, 2005). In Victoria, intimate partner violence is the leading contributor to premature death, illness and injury for women of childbearing age (VicHealth, 2004).

At the hospital, we have a Violence Against Women Strategy aimed at addressing the needs of women who have experienced violence, as well as the needs of the multidisciplinary health professionals who provide support and treatment. Research into this Strategy from the perspective of staff who work within it has never been undertaken. Research into health system responses to VAW have been extremely limited, with none looking at the personal experiences of staff.

What is The WAV Project?

We have called this PhD project ***The Women Against Violence (WAV) Project.*** The Project aims to research the hospital’s VAW Strategy. The first phase of this Project was a large-scale survey of clinicians at the hospital about the work with patients affected by violence, their opinions about VAW as well as their personal experiences of domestic violence and sexual assault and the impact of this on clinical work, and the workplace. Informed by the findings of the survey, Phase II of this project will involve interviewing a small number of key stakeholders for more in-depth information about the role of the hospital workplace in responding to staff after violence has occurred. It is possible that a key stakeholder contacted for an interview will have also participated in Phase I of the research – the health professional survey, and there is no problem associated with this. This project has received ethical approval by both the hospital and The University of Melbourne.

Purpose of the interviews with key stakeholders

We believe that managers, members of the hospital executive and other senior figures in the broader health industry have particularly important and unique perspectives on the role of the workplace in responding to employees after violence has occurred. For this reason, we are seeking to conduct short, structured interviews with 10-20 key stakeholders to discuss how employers can respond to staff's personal experiences of VAW; and, how the hospital can support the clinical work with patients who have experienced VAW.

Who are the researchers?

We have practitioner Social Work and General Practice backgrounds and work at the University of Melbourne:

Ms Elizabeth McLindon

Social worker & sexual assault counsellor at the hospital, PhD Candidate

Professor Kelsey Hegarty

General Practice & Primary Health Care Academic Centre

Professor Cathy Humphreys

Department of Social Work

Why am I being sent this information?

You have been sent this information because we would like to hear your views about the violence against women agenda at the hospital, specifically, the role of a hospital in responding to staff who may have experienced domestic violence and/or sexual assault. It is your choice whether to participate.

What will I be asked to do?

We invite you to participate in a short, structured interview lasting 30 minutes to an hour. The interviewer is Liz McLindon, the PhD candidate for this project and an employee of the hospital for the last six years, currently at the sexual assault service. The interview can take place in a location of your choosing, including your office, or over the phone, or at The University of Melbourne. Prior to beginning the interview, you will be asked to sign a consent form. We would like to audiotape the interview if you are comfortable with that, if you are not, we would like to take notes.

Will there be any benefits to doing the study?

As a result of this study we hope to make improvements for both women who have experienced violence and staff at the hospital.

How will my confidentiality be protected?

Any information you provide will be treated as **confidential,** however absolute anonymity cannot be guaranteed due to the small size of the interview sample. Maintaining confidentiality is very important to us. All of the information you provide will not be directly linked to either you or your role. You will have the choice to review the audio recording of your interview (assuming you consented to audio recording at the time of the interview) and notes taken from your interview. If you withdraw your consent for participation in this project, as is your choice at any time, then any unprocessed data will be destroyed.

How will the survey data be stored?

All information you provide will be kept secure, in locked storage at the Department of General Practice, The University of Melbourne. Any audio taken and interview notes will be stored using a code, not your name. The research data and records will be kept for a minimum of five years after publication, or public release, of the research. It will then be destroyed in accordance with the University guidelines. Any publications or presentations to arise from this research will contain aggregate data only, so participants will not be able to be identified.

How will I find out the results of The WAV Project?

Upon completion of **The WAV Project,** a report of the findings will be presented to the hospital and this will be available to you. The Communications Department will announce this across the hospital at that time. In addition, any publications or conference presentations to emerge from the findings will also be announced to all staff by the Communications Department.

Who can I talk to about the project if I have concerns or experience distress in relation to any of the issues raised?

If you have any questions about the project, please contact one of the researchers:

- Liz McLindon (03) 8344 4102,
- Kelsey Hegarty (03) 8344 7276,
- Cathy Humphreys (03) 8344 9427.

If you want to talk about any concerns for your own well-being you can contact:

- Employee Assistance Program 1300 360 364
- 1800RESPECT 1800 737 732

Or you can find a full list of resources via the project website:
www.gp.unimelb.edu.au/wavproject/resources.html

If you have any complaints or concerns about the conduct of this project please contact the hospital Human Research Ethics Committee Secretariat on (03) _____________.

How do I agree to participate?

If you would like to participate, please send an email to Liz McLindon (elizabeth.mclindon@thehospital.org.au) to arrange an interview time. To discuss any issues further, you can call Liz on 04_______________.

Thank you very much for taking the time to read this information.

Appendix R. Consent form (Interviews)

THEWAVPROJECT

Phase II **Talking with Senior Managers**

Interview Consent Form

I consent to voluntarily participate in **The WAV Project**, the particulars of which are listed below:

- Read the information sheet (Plain Language Statement) (5 minutes);
- Participate in an interview about the violence against women (VAW) strategy at the hospital (no more than 1 hour);

A written copy of **The WAV Project** information has been given to me to keep;

I acknowledge that:

(a) The possible effects of the project have been explained to me to my satisfaction;

(b) I have been informed that I am free to access the audio file and review the notes written after my interview;

(c) I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data previously supplied;

(d) I have been informed that the confidentiality of the information I provide will be safeguarded, but that absolute anonymity cannot be guaranteed due to the small size of the interview sample.

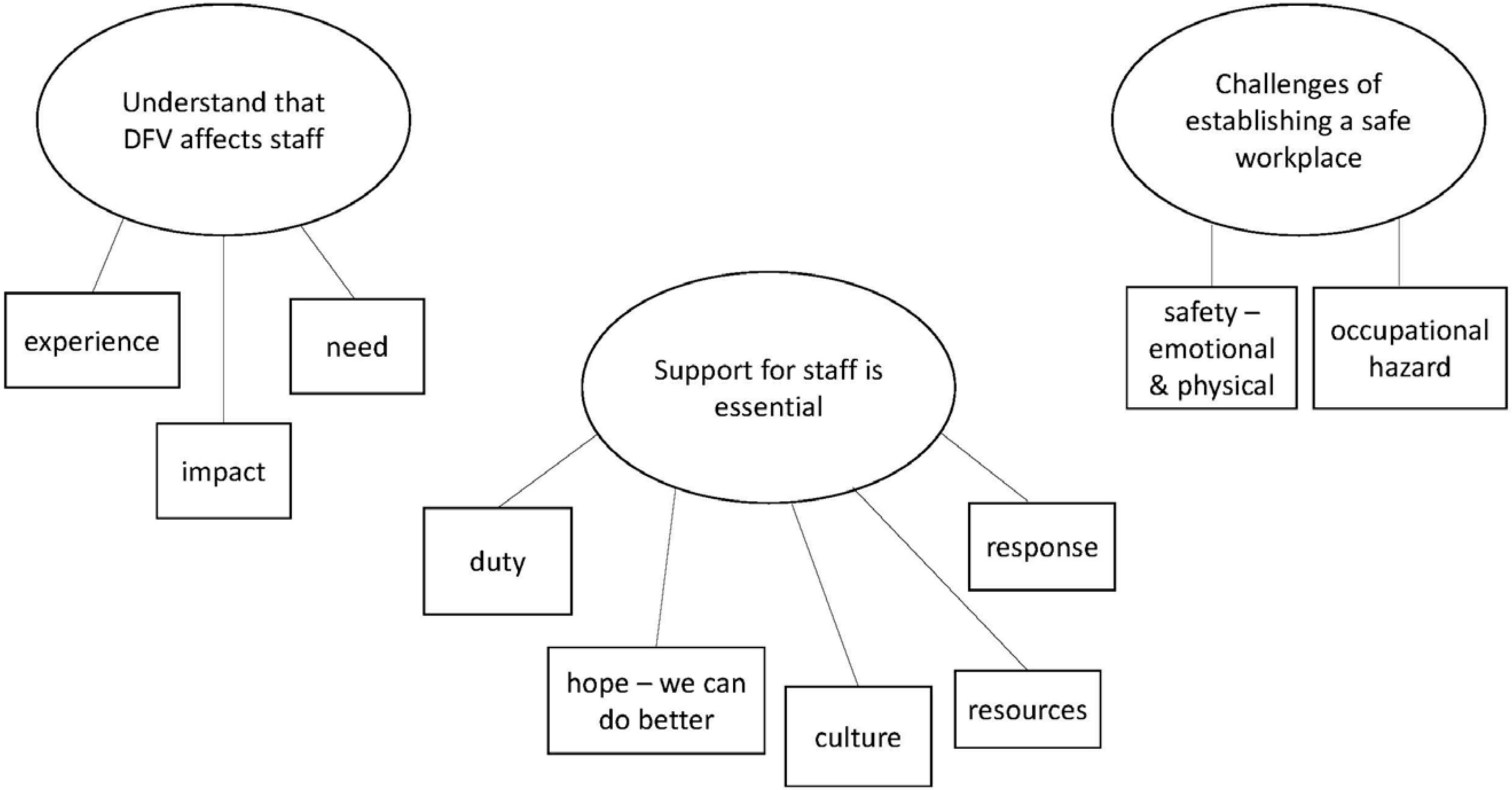
Participant name:

____

Signature:

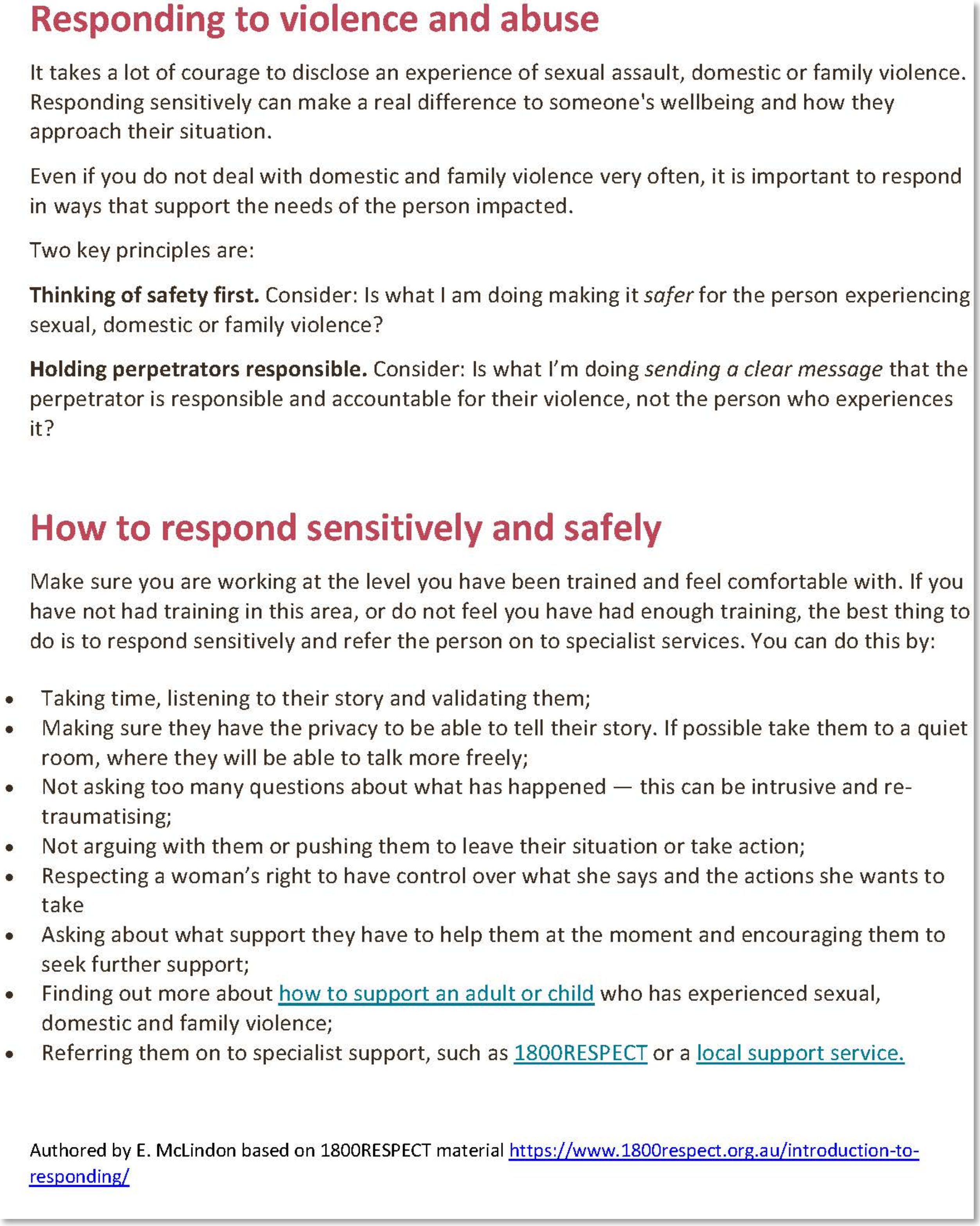
____

Appendix S. Thematic Map – Hospital workplace support for survivor staff



Thematic map showing final three main themes

Appendix T: Further resources for recruiting hospital



Responding to violence and abuse

It takes a lot of courage to disclose an experience of sexual assault, domestic or family violence. Responding sensitively can make a real difference to someone's wellbeing and how they approach their situation.

Even if you do not deal with domestic and family violence very often, it is important to respond in ways that support the needs of the person impacted.

Two key principles are:

Thinking of safety first. Consider: Is what I am doing making it *safer* for the person experiencing sexual, domestic or family violence?

Holding perpetrators responsible. Consider: Is what I'm doing *sending a clear message* that the perpetrator is responsible and accountable for their violence, not the person who experiences it?

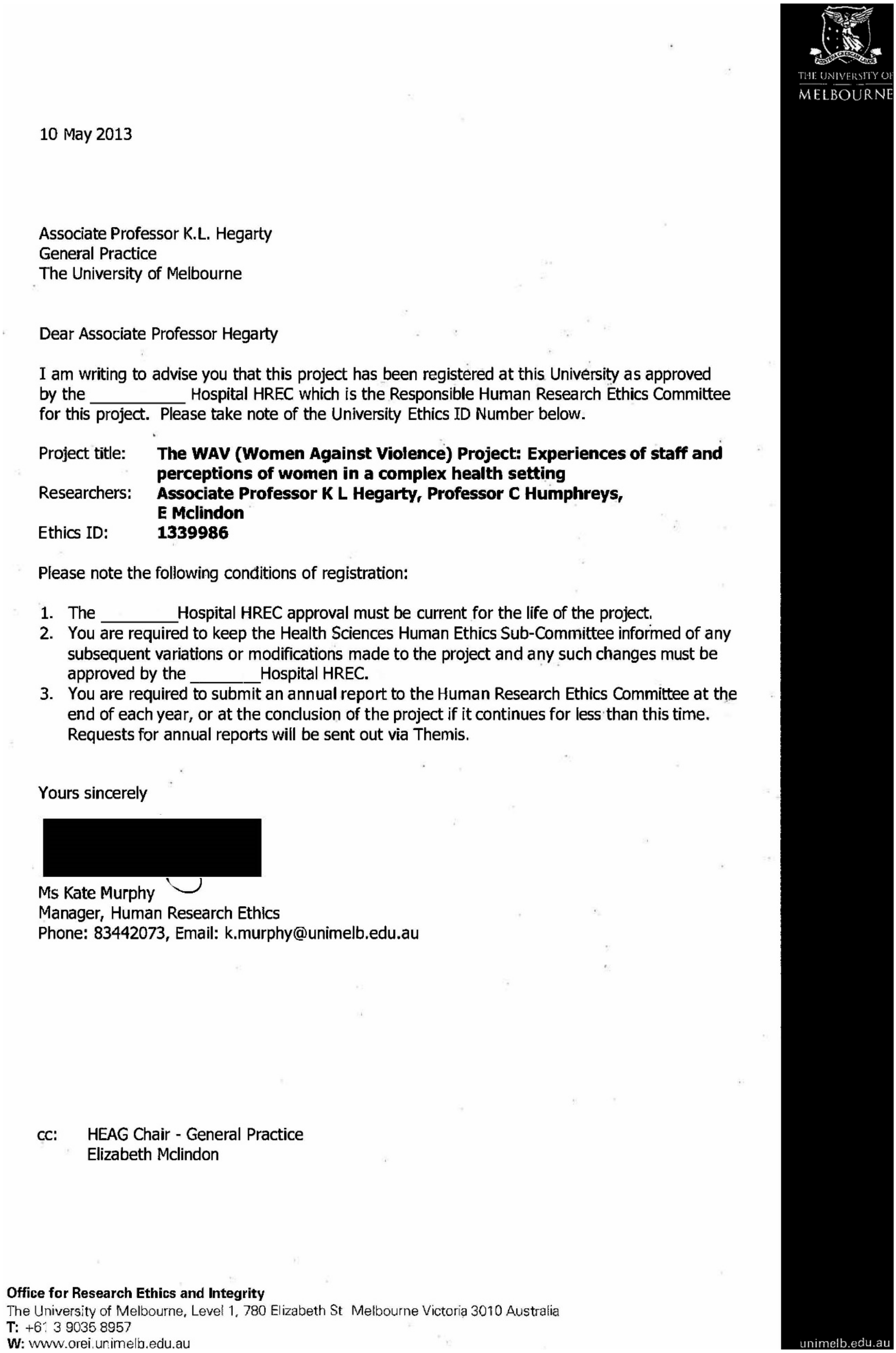
How to respond sensitively and safely

Make sure you are working at the level you have been trained and feel comfortable with. If you have not had training in this area, or do not feel you have had enough training, the best thing to do is to respond sensitively and refer the person on to specialist services. You can do this by:

- Taking time, listening to their story and validating them;
- Making sure they have the privacy to be able to tell their story. If possible take them to a quiet room, where they will be able to talk more freely;
- Not asking too many questions about what has happened — this can be intrusive and re-traumatising;
- Not arguing with them or pushing them to leave their situation or take action;
- Respecting a woman's right to have control over what she says and the actions she wants to take
- Asking about what support they have to help them at the moment and encouraging them to seek further support;
- Finding out more about how to support an adult or child who has experienced sexual, domestic and family violence;
- Referring them on to specialist support, such as 1800RESPECT or a local support service.

Authored by E. McLindon based on 1800RESPECT material https://www.1800respect.org.au/introduction-to-responding/

Appendix U. Ethics approval



THE UNIVERSITY OF
MELBOURNE

10 May 2013

Associate Professor K.L. Hegarty
General Practice
The University of Melbourne

Dear Associate Professor Hegarty

I am writing to advise you that this project has been registered at this University as approved by the __________ Hospital HREC which is the Responsible Human Research Ethics Committee for this project. Please take note of the University Ethics ID Number below.

Project title: **The WAV (Women Against Violence) Project: Experiences of staff and perceptions of women in a complex health setting**
Researchers: **Associate Professor K L Hegarty, Professor C Humphreys, E Mclindon**
Ethics ID: **1339986**

Please note the following conditions of registration:

1. The ________Hospital HREC approval must be current for the life of the project.
2. You are required to keep the Health Sciences Human Ethics Sub-Committee informed of any subsequent variations or modifications made to the project and any such changes must be approved by the ________Hospital HREC.
3. You are required to submit an annual report to the Human Research Ethics Committee at the end of each year, or at the conclusion of the project if it continues for less than this time. Requests for annual reports will be sent out via Themis.

Yours sincerely

[redacted]

Ms Kate Murphy
Manager, Human Research Ethics
Phone: 83442073, Email: k.murphy@unimelb.edu.au

cc: HEAG Chair - General Practice
Elizabeth Mclindon

Office for Research Ethics and Integrity
The University of Melbourne, Level 1, 780 Elizabeth St Melbourne Victoria 3010 Australia
T: +61 3 9035 8957
W: www.orei.unimelb.edu.au

unimelb.edu.au

Appendix V. STROBE Statement (Paper 2)

STROBE 2007 (v4) Statement—Checklist of items that should be included in reports of *cross-sectional studies* accompanying Impacts Paper 2

Section/Topic	Item #	Recommendation	Reported on page #
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	1
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	1
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	2-3
Objectives	3	State specific objectives, including any prespecified hypotheses	3
Methods			
Study design	4	Present key elements of study design early in the paper	3
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	3
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants	3
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	4
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	4
Bias	9	Describe any efforts to address potential sources of bias	6
Study size	10	Explain how the study size was arrived at	6
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	4

Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	4
		(*b*) Describe any methods used to examine subgroups and interactions	N/A
		(*c*) Explain how missing data were addressed	7-8 specify the number and percentage of missing data. Since less than 5% of the data was missing, we employed the '95% rule' which says that 'different treatments of missing values will have little or no impact on the substantive interpretations as 95 per cent of the observations are available for use'
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	N/A
		(*e*) Describe any sensitivity analyses	N/A
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	5
		(b) Give reasons for non-participation at each stage	5
		(c) Consider use of a flow diagram	Thesis page 89
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	10
		(b) Indicate number of participants with missing data for each variable of interest	10-13
Outcome data	15*	Report numbers of outcome events or summary measures	N/A
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	4-5
		(*b*) Report category boundaries when continuous variables were categorized	N/A
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	N/A
Discussion			

Key results	18	Summarise key results with reference to study objectives	5-6
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	6
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	5-7
Generalisability	21	Discuss the generalisability (external validity) of the study results	7
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	9

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

Appendix W. Chapter opening quotes – Participants

Chapter 1, page 2

Survivor health professional participant: 258

Health professional participant: Sarah

Chapter 2, page 15

Survivor health professional participant: 521

Health professional participant: Helen

Chapter 3, page 65

Survivor health professional participant: 383

Health professional participant: Anna

Chapter 4, page 118

Survivor health professional participant: 148

Health professional participant: David

Chapter 5, page 134

Survivor health professional participant: 258

Health professional participant: Annette

Chapter 6, page 148

Survivor health professional participant: 80

Health professional participant: Louise

Chapter 7, page 172

Survivor health professional participant: 399

Health professional participant: Anthony

Chapter 8, page 197

Survivor health professional participant: 505

Health professional participant: Anthony

Appendix X. Workplace support program

Family Violence Workplace Support Program Overview

Updated 1 August 2018

Background

Family violence is a workplace issue that impacts upon staff personally, often affecting attendance at work, performance, productivity and workplace safety. The SHRFV approach recognises that as employers, we must prioritise the safety and wellbeing of our staff who personally experience family violence. Not only does this priority arise from our role as an employer, as a health service provider we must support our staff personally so that they can support patients experiencing family violence.

The Family Violence Workplace Support program, outlined in this overview, was developed by _____________ Hospital in 2016 and now forms a critical program within the SHRFV whole-of-hospital approach.

To create a safe and supportive work environment for those experiencing family violence and as part of a whole-of-hospital approach, your health service needs to adapt your operating environment to include the following key components of the SHRFV Family Violence Workplace Support program.

Leadership commitment

To ensure success, it is critical that your health service's leadership team is demonstrably committed to supporting staff experiencing family violence. The leadership team models and actively promotes:

- the acknowledgement that family violence is a workplace issue and that staff experiencing family violence will be supported by the health service
- a workplace culture that fosters respectful relationships between men and women
- gender equality and diversity within the workplace

Leadership commitment can be enhanced through Board and Executive briefings and the appointment of an Executive sponsor. Presentations or information sessions can be an effective forum to build a shared understanding of the project and to seek the buy in of the broader management group within your health service.

Organisational culture and strategic priorities

The commitment to responding to employees experiencing family violence and prevention work can be strengthened by its inclusion in overarching documents such as your health service's strategic plan, relevant organisational strategies – for example your People Strategy –and, if possible, your Statement of Priorities (the annual accountability agreement between your health service and the Minister for Health).

Ideally, your health service's culture and values should be actively aligned with family violence response and prevention work because it is explicitly acknowledged that sexism and gender based discrimination within the workplace contributes to a society where family violence can flourish.

Policy, procedure and industrial instruments

Since late 2016, renegotiated enterprise bargaining agreements within the Victorian public health sector have included a Family Violence Leave clause, covering most employees within the sector. It is essential that your Family Violence Workplace Support program meets the requirements of the Family Violence Leave clause. Some of the key provisions arising from this clause include:

- the entitlement to paid/unpaid leave for those experiencing family violence and to use sick leave in particular circumstances to support others experiencing family violence
- the requirement to appoint and train Family Violence Contact Officers
- confidentiality requirements
- right to reasonable adjustments to provide support and enhance safety
- the provision of external referral information

However, a family violence workplace support program is more than compliance with this clause. Your health service will need clear policies, procedures and codes of conduct in place which communicate:

- that family violence is a gendered issue, is situated in the broader context of unequal relationships between men and women and that different aspects of an employee's identity such as being Aboriginal or Torres Strait Islander, will overlap to shape an experience of family violence.
- how your health service will support employees experiencing family violence, including entitlements
- the expectation that employees and contractors will treat others with respect: they will not sexually harass, bully or discriminate against colleagues, patients and others in the course of their work

- the process for addressing inappropriate behaviour within the workplace
- the consequences for perpetrating an act of family violence using work resources and time
- health, safety and risk policies and procedures work to enhance workplace safety that may be compromised by family violence

An example policy and procedure your health service can adapt and use as part of your Family Violence Workplace Support Program is available in the SHRFV Toolkit of Resources.

Communication

Your health service will need to regularly and clearly communicate both to external and internal audiences to reinforce your key family violence response and prevention messages.

Employees should have access to information about the Family Violence Workplace Support Program, including external referral information, which should be tailored having regard to language and literacy levels, access to computers and working outside of standard business hours.

Examples of communication channels include orientation, newsletters, brochures, cards, intranet, posters, employee on-boarding information, meetings and events (such as staff BBQs, Grand Rounds, staff forums), CEO and leadership speeches.

Training

All those who manage or supervise staff need to attend training on preventing and responding to family violence. The training builds manager capability in understanding the drivers of family violence and to identify and respond to an employee experiencing family violence. Managers understand the impact of family violence within the workplace and the expectations and boundaries in relation to their role as managers in responding to employees experiencing family violence. It is important that managers understand the complexities and dangers that family violence presents and that their management practice in supporting an employee enhances the safety and wellbeing of that employee.

Manager training is also central to effectively communicating the importance of a respectful, inclusive and non-discriminatory workplace culture in effectively using the workplace as a setting for family violence prevention. Managers are given appropriate support to develop their capabilities in this area. It is strongly recommended that there is clear communication to managers on where they can seek assistance post training if they need further support. Health services should consider making manager training is mandatory as part of the Family Violence Workplace Support Program.

Employees should also be given the (non-compulsory) opportunity to attend training in relation to understanding family violence, the workplace supports available to those experiencing family violence, including external referral information.

Training modules for managers and staff have been developed specifically for the SHRFV program (see the SHRFV Toolkit of Resources) and moderate adaptations can be made to suit your operating environment. It is recognised that health services may not have the internal expertise or capacity to deliver training and where this is the case, partnering with a credible external training provider to deliver this training is suitable.

Family Violence Contact Officers

Establishing the role of Family Violence Contact Officers as part of your Family Violence Workplace Support Program is a requirement under the Family Violence Leave clause. These roles need to be in place to assist employees with information about the workplace supports available such as referral information, family violence leave, safety planning and other workplace supports. They may be members of the Human Resources/People & Culture team and/or drawn from employees across your organisation and act as an alternative source of information where an employee does not wish to discuss their situation with a manager. Where your health service is located in a rural/regional setting, consideration needs to be given to a model of Family Violence Contact Officer that enhances confidentiality if necessary. Examples of shared models may include employee access to Family Violence Contact Officers from neighbouring health services or a project lead hospital offering Family Violence Contact Officers centrally.

Family Violence Contact Officers should be provided with family violence training to build understanding of the drivers of family violence, appropriate responses to disclosures of family violence, confidentiality requirements, the range of workplace supports available to employees and responsibilities of the role as assigned by your health service. The name and contact details of Family Violence Contact Officers need to be well promoted with in the workplace.

Partnerships & collaboration

As part of the Family Violence Workplace Support Program your health service needs to develop and/or strengthen its partnerships with external organisations with expertise in family violence to improve outcomes for employees. Organisations such as the Employee Assistance Program provider, local family violence services and women’s health organisations can be a source of consultation in relation to the Family Violence Workplace Support Program as well as providing referral pathways for staff.

Employees with relevant expertise within the health service should ideally work together to collaborate and support each other in developing, implementing and sustaining the Family Violence Workplace Support Program.

Evaluation and improvement

The Family Violence Workplace Support Program should be evaluated periodically to measure improvement in workforce understanding of family violence and to ensure that processes undertaken to support those experiencing family violence meet the needs of staff. Such information can be drawn from areas such as:

- pre and post training surveys and verbal feedback providing qualitative and quantitative data collected at all training sessions and other staff surveys
- data collection and record keeping around all program activities such training attendance, the number of staff who have accessed family violence leave and total hours taken, attendance at relevant grand rounds, staff forums and promotional events, number of visits to the relevant intranet page to access internal family violence information, reports from the EAP provider on family violence related contacts
- regular training content evaluation meetings to ensure continuous quality improvement and best practice
- periodic policy and procedure review and intranet information review
- regular meetings within Human Resources/People & Culture to keep up to date with current procedures relating to the Family Violence Workplace Support Program.

Further information/relevant tools

- Family violence workplace support policy and procedure
- Family violence workplace support manager training – training presentation and facilitators guide
- Family violence workplace support staff training – training presentation and facilitators guide
- Introduction to SHRFV – orientation presentation
- Managers guide to workplace safety planning
- Family violence workplace support brochure
- Family violence workplace support intranet content
- Senior Management Engagement presentation

Appendix Y. Media

Radio:

- Interview with Jon Faine at 774 ABC Melbourne (3 July 2018)
- 2SER (4 July 2018)

TV (3 July 2018):

- Channel 10 nightly news
- Channel 9 nightly news
- SBS nightly news

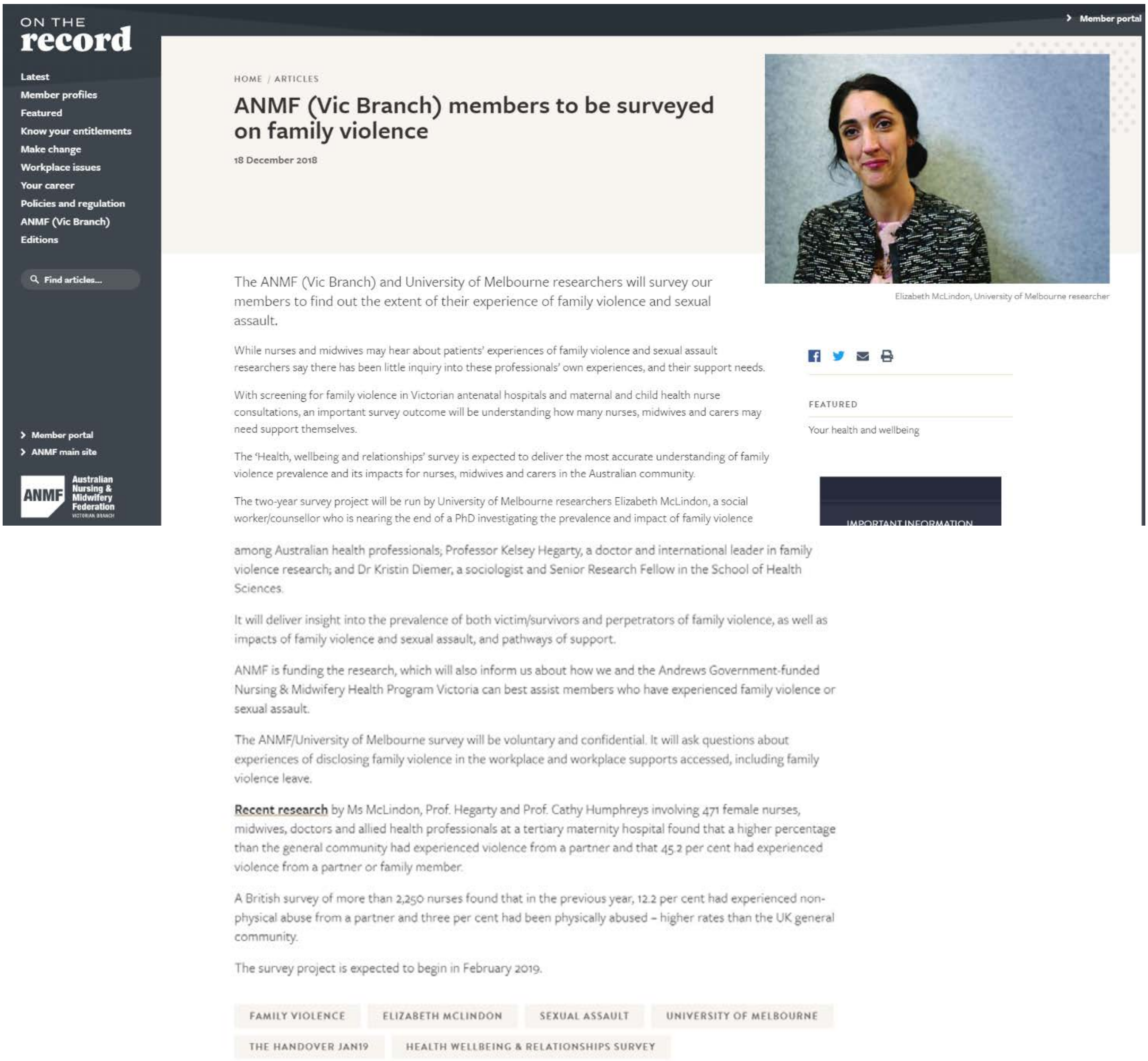
Online news:

- ABC News Online, 4 July 2018 (https://www.abc.net.au/news/2018-07-03/nearly-half-of-female-medical-staff-experience-domestic-abuse/9931542?nw=0)
- ANMF On the Record (3 July 2018) https://otr.anmfvic.asn.au/articles/high-prevalence-of-family-violence-among-female-health-professionals-study-finds
- Health Times (10 August 2018) https://healthtimes.com.au/hub/womens-health/58/news/hw/female-healthcare-workers-twice-as-likely-to-encounter-partner-violence/3540/
- The Nursing Review (30 August 2019)

Book:

- Reference in Jess Hill's book 'See What You Made Me Do' (Black Inc.)

Appendix Z. Postdoctoral research



ANMF (Vic Branch) members to be surveyed on family violence

18 December 2018

Elizabeth McLindon, University of Melbourne researcher

The ANMF (Vic Branch) and University of Melbourne researchers will survey our members to find out the extent of their experience of family violence and sexual assault.

While nurses and midwives may hear about patients' experiences of family violence and sexual assault researchers say there has been little inquiry into these professionals' own experiences, and their support needs.

With screening for family violence in Victorian antenatal hospitals and maternal and child health nurse consultations, an important survey outcome will be understanding how many nurses, midwives and carers may need support themselves.

The 'Health, wellbeing and relationships' survey is expected to deliver the most accurate understanding of family violence prevalence and its impacts for nurses, midwives and carers in the Australian community.

The two-year survey project will be run by University of Melbourne researchers Elizabeth McLindon, a social worker/counsellor who is nearing the end of a PhD investigating the prevalence and impact of family violence among Australian health professionals; Professor Kelsey Hegarty, a doctor and international leader in family violence research; and Dr Kristin Diemer, a sociologist and Senior Research Fellow in the School of Health Sciences.

It will deliver insight into the prevalence of both victim/survivors and perpetrators of family violence, as well as impacts of family violence and sexual assault, and pathways of support.

ANMF is funding the research, which will also inform us about how we and the Andrews Government-funded Nursing & Midwifery Health Program Victoria can best assist members who have experienced family violence or sexual assault.

The ANMF/University of Melbourne survey will be voluntary and confidential. It will ask questions about experiences of disclosing family violence in the workplace and workplace supports accessed, including family violence leave.

Recent research by Ms McLindon, Prof. Hegarty and Prof. Cathy Humphreys involving 471 female nurses, midwives, doctors and allied health professionals at a tertiary maternity hospital found that a higher percentage than the general community had experienced violence from a partner and that 45.2 per cent had experienced violence from a partner or family member.

A British survey of more than 2,250 nurses found that in the previous year, 12.2 per cent had experienced non-physical abuse from a partner and three per cent had been physically abused – higher rates than the UK general community.

The survey project is expected to begin in February 2019.

FAMILY VIOLENCE
ELIZABETH MCLINDON
SEXUAL ASSAULT
UNIVERSITY OF MELBOURNE
THE HANDOVER JAN19
HEALTH WELLBEING & RELATIONSHIPS SURVEY

The appendices are concluded, and this thesis is complete.

Thank you for reading.

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Author/s:
McLindon, Elizabeth Veronica-Mary

Title:
"It happens to clinicians too": The prevalence, impact and implications of domestic and family violence against health professional women

Date:
2020

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